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## **Assessing approaches to appraisal**

### **A comparison of performance appraisal practices and consequences for hospital nurses in the Czech Republic and Germany**

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King's College London

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**ASSESSING APPROACHES TO APPRAISAL: A COMPARISON OF  
PERFORMANCE APPRAISAL PRACTICES AND CONSEQUENCES FOR  
HOSPITAL NURSES IN THE CZECH REPUBLIC AND GERMANY**

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## Abstract

The plethora of research on performance appraisal (PA) is heavily concerned with micro-level issues in relation to the PA process. There is a need for a wider perspective which takes the influence of distal factors stemming from the national institutional context into account (DeNisi and Murphy, 2017). To address this gap, this thesis adopts an institutional perspective to assess PA practices in public hospitals and how it affects nurses – a key occupational group in healthcare - in the Czech Republic and Germany. This research contributes to the PA literature by investigating how national institutions shape the character and consequences of PA.

The research adopts a mixed-method comparative case-study design which allows for an in-depth and nuanced understanding of nurses' PA. In total, 107 semi-structured interviews were conducted. The first research phase constituted interviews with national stakeholders (e.g. representatives from trade unions, nursing and employer associations). In the second phase, detailed fieldwork was conducted in two hospitals in each country. This included the collection of documentary evidence, interviews (e.g. with general nurses, nursing managers, hospital management, works councillors) and a survey amongst general nursing staff (n=500).

The findings of the case-study analysis confirm distinct national approaches to PA. In Germany, PA can be identified to be predominantly 'developmental' and 'nurturing' whereas in the Czech Republic, PA tends to be orientated towards 'judgement' with elements of 'control'. The research identifies key national institutions which led to these variations: in Germany, the influential works council and in the Czech Republic external accreditation requirements. Although national models of PA can be permissive to variation, a clear tendency in each country was ascertained. The nature of PA was found to have implications for how nurses perceive and react to PA. When faced with more 'judgemental' and 'controlling' types of PA, nurses became discontented with the process. When predominantly 'developmental' in nature, PA had positive connotations for nurses.

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## Glossary of terms/ acronyms

CEE	Central and Eastern Europe
CME	Coordinated Market Economy
DRG	Diagnostic Related Group
EU	European Union
FTE	Full-time Equivalent
HCA	Healthcare Assistant
HI	Historical Institutionalism
HRM	Human Resource Management
ISO	International Organisation for Standardisation
LME	Liberal Market Economy
NPM	New Public Management
NRW	Nordrhein-Westfalen (German state: North Rhine-Westphalia)
PRB	Performance-related bonus
PA	Performance Appraisal
RI	Rational choice Institutionalism
RP	Rheinland-Pfalz (German state: Rhineland-Palatinate)
SHI	Social Health Insurance
SI	Sociological Institutionalism
TVöD	Tarifvertrag für den Öffentlichen Dienst (collective bargaining agreement for the public sector)
VoC	Varieties of Capitalism
WC	Works Council

## Chapter 1: Introduction

### 1.1 Background

Over the past two decades, public services across Europe have been under increasing pressure to perform in the face of growing demands for efficiency and simultaneous calls for higher quality services (e.g. OECD, 2005; OECD, 2011; Lindlbauer et al., 2016; Rotar et al., 2016). Particularly in the healthcare sector, these pressures have been heightened since the economic crisis, and achieving value for money has become one of the greatest challenges (OECD, 2010) whilst maintaining and demonstrating quality. The emphasis on performance in public sector organisations is also manifested in approaches to public management reform and trends, which have implied a greater focus on performance management at both the organisational and individual level (Hood, 1991, 1995; Pollitt and Bouckaert, 2004) as well as a focus on quality (e.g. Giaque, 2003). This thesis is concerned with approaches to performance appraisal (PA), an essential performance-orientated practice concerned with performance at the individual or team level, in public sector hospitals in two different EU countries, the Czech Republic and Germany, with a focus on general nurses, a key occupational group as the largest group of the workforce in healthcare globally (Hart, 2015; WHO, 2017).

There is a general acknowledgement that the use of PA has increased substantially in recent years and that this practice has been extended to larger parts of the workforce not traditionally covered by PA, including professional staff (Keizer, 2011; Krausert, 2009; Prowse and Prowse, 2009). In the public sector, the higher incidence of PA is often connected to increased demands for higher efficiency and accountability (Decramer et al., 2012; Martinez, 2001; Perrin, 1998), including in healthcare (Brunetto and Farr-Wharton, 2004; Bolton, 2004; McGivern and Ferlie, 2007). Still, it is not clear if PA is being used in similar ways in hospitals across countries due to shared performance pressures in terms of efficiency and quality or if differences in the national institutional context leads to variation. Furthermore, it is unclear why exactly similarities or differences prevail, e.g. which national institutions shape PA practices in what ways, and what the outcomes and experiences are for nurses in practice. Although the performance management agenda in the context of the public sector has been widely debated, the practice of PA has received little research attention (Bach and Kessler, 2012), let alone from a comparative perspective.

Instead, the majority of conventional PA literature is heavily concerned with micro-level issues in relation to the appraisal process. A lot of research tends to focus for example on issues such as the development and use of rating scales, how to evaluate performance accurately, how

judgements are formed and how biases can be minimised (DeNisi and Murphy, 2017). Previous research has also considered issues such as the motivation of appraisers and appraisees as well as individual differences and appraiser-appraisee relations (Levy and Williams, 2004). In their intensive review of HRM research over the last 23 years, Markoulli et al. (2017) identify one of the five major HRM-topics to be related to 'assessing performance' within which most research is concerned with the practice of PA. Again, whilst a variety of issues have been examined by the PA literature, the emphasis is clearly on the microlevel, including for example on specific appraisal techniques (Budworth et al., 2015; Kluger and Nir, 2010), or its effect on discrimination and diversity (Hennessey and Bernardin, 2003).

Thus, despite decades of research on PA and advancements in the understanding of the more immediate setting of PA, much of the PA literature has been "decontextualized, examining different facets of the rating process (...) in isolation" (DeNisi and Murphy, 2017, p.429). Therefore, the need to put PA into context whilst adopting a holistic view of the PA process is emphasised (e.g. DeNisi and Murphy, 2017; Levy and Williams, 2004; Ikramullah et al., 2016) to be able to discern the linkages between the national context and the various dimensions of the practice of PA and its outcomes. Indeed, Meyer (2014) stresses the benefits of developing a "big picture perspective" (p. 379) to generate further knowledge of a phenomenon including its antecedents and consequences in practice. This involves the investigation of the circumstances under which PA systems are introduced and practiced beyond the organisation (DeNisi and Murphy, 2017) as well as the outcomes it has for those individuals subjected to PA.

So far, we know very little about how more distal factors influence approaches to appraisal (DeNisi and Murphy, 2017; Djurdjevic and Wheeler, 2014; Levy and Williams, 2004), like those stemming from the national institutional context, such as the industrial relations system, especially employee voice mechanisms, quality assurance systems and national labour laws. This coincides with the lack of research taking a cross-national comparative perspective especially in relation to public sector organisations (Wang et al., 2017) as PA research generally tends to focus on the private sector (Kim and Holzer, 2016). Cross-country comparisons are however vital to be able to identify the impact contextual factors have on this or any other phenomenon (Johns, 2001, 2006; Rousseau and Fried, 2001). Specifically, regarding public-sector organisations, the need for more cross-national comparisons and research on the impact of national-level contextual factors in relation to PA is stressed (Wang et al., 2017).

This thesis extends the research literature on PA by assessing how national institutions impact at the organisational level and shape PA in hospitals, and how this affects the way in which PA is practiced and perceived by hospital nurses in the Czech Republic and Germany. The country

cases have been selected on the basis that they represent distinct classifications, i.e. Germany typifies a coordinated market economy and the Czech Republic an *emergent* liberal market economy specifically in terms of its employment relations system (Hall and Soskice, 2001; King, 2007). Such differences in the national institutional context are expected to lead to variations regarding nurses' PA. This thesis benefits from the incorporation of a thus far under-researched country as the Czech Republic. Comparative research in this area still focuses predominantly on Anglophone countries alongside some Western European countries, and certain regions of Asia such as Japan (e.g. Keizer, 2011) but largely neglects Central Eastern European countries (see e.g. Cooke et al., 2017; Bach and Bordogna, 2016). Therefore, the inclusion of the Czech Republic, still considered 'in transition' following the fall of Communism in 1989, despite many significant changes (including its accession to the EU), is a particular strength of this study and relates to the comparative advantage of the researcher (see chapter 4). Although being of German nationality, having the ability to speak Czech fluently due to a Czech background and a concomitant cultural understanding and personal interest in both countries, presented itself as an ideal opportunity to study these two countries in-depth. Having lived in the UK for the last 10 years provided the researcher with sufficient distance to conduct effective comparisons between the two countries. Moreover, this study builds on the researcher's MSc thesis which concentrated on the Czech hospital sector and which originally motivated the interest in this topic.

It is important to investigate the state of PA in hospitals across different countries and further our understanding of the potential constraints and opportunities stemming from the institutional context for different approaches to PA because not only can PA affect individuals in important ways, but effective PA can result in improved patient outcomes. For example, at the individual level it is suggested that the practice of PA *can* help to alleviate stress in the workplace for nurses (Wright, 2014), help motivate nurses (Baard and Neville, 1996) and even create trust and a sense of purpose for nurses within the workplace (MacKenzie and MacKenzie, 1995). At the broader level, evidence has shown that effective PA in the hospital context can lead to improved patient care and reductions in patient mortality (West et al., 2002) and is ultimately recommended to enhance public protection (Francis, 2013).

This research focuses on nurses because they represent the largest occupational group in healthcare, make up a significant proportion of labour costs, and because their role involves a high degree of interaction with patients and, therefore, has a significant impact on patient outcomes and patient satisfaction (Stone et al., 2011). Furthermore, this thesis concentrates on hospitals because they are a dominant part of any healthcare system, including in terms of their

proportion of healthcare budgets and impact on health (McKee and Healy, 2002; Jeurissen et al., 2016). However, thus far little is known about hospital nurses' PA in different EU countries or the way in which nursing as a profession may influence PA and how nurses react to different forms of appraisal.

There is a consensus that, whatever the approach to PA, its ultimate, overarching aim is to manage and improve individual performance and by extension organisational performance (Brown et al., 2010). However, at the same time, PA is considered as one of the most problematic, most unpopular and indeed detested HR practices (e.g. Cappelli and Conyon, 2017) and remains a core challenge for organisations (Keizer, 2011). Therefore, it is crucial to understand why PA systems are introduced in the first place, i.e. which broader national factors lead hospitals to introduce specific types of PA and for which purposes, and how this in turn shapes the PA process itself and consequences in practice.

## 1.2 Aim of the thesis

As highlighted in the preceding section, since the conventional literature on PA, further discussed in Chapter 2, tends to concern itself with the micro-level to the exclusion of the wider national context within which PA systems are created and practiced, we know very little about the extent to which similarity or variation can be identified in hospitals across countries and how distal factors stemming from the national institutional context influences approaches to PA and experiences of PA at local level.

This research seeks to enrich the PA literature by taking a broader view. The core aim of this research is to assess the impact of national institutions on PA and to identify whether and which national institutions have shaped PA systems and their implementation at the organisational level and what the consequences for nurses are. The main research question is whether similarities in terms of general hospital pressures across Europe will lead to similar PA approaches with similar consequences for nurses or if these pressures are moderated by distinct national institutions, leading to different PA approaches and consequences for nurses.

### **Research Questions:**

- 1. Do shared hospital pressures lead to similar PA approaches?***
- 2. Do differences in the national institutional context lead to distinct PA approaches?***
- 3. What is the overall outcome of (different forms of) PA?***

The thesis seeks to answer these questions by examining the approaches to PA and comparing their similarities and differences in relation to three dimensions: *why* PA systems are introduced for nurses, *how* PA is practiced, and *what* the consequences of PA are for nurses through detailed fieldwork in two hospitals in each of the countries under investigation, namely the Czech Republic and Germany. Thereby the thesis seeks to shed light on how exactly national institutions influence PA at different levels.

**Dimensions:**

1. **‘Why’** is performance appraisal (PA) introduced for nurses in public sector hospitals in the Czech Republic and in Germany?
2. **‘How’** is it practiced? What form does PA take in practice?
3. **What** are the **consequences**: in what ways does nursing staff perceive and react to PA?

The research questions are concerned with the question of similarity (i.e. convergence) versus difference (i.e. divergence) regarding PA, while the dimensions are the sub-questions and are concerned with specific aspects of the PA practice (its purpose, its process, and consequences) and which are the focus of comparison, to be able to address the core question of similarity and difference. The research questions are reflected in the so-called convergence-divergence paradigm. The debates around convergence and divergence, explored in chapter 3, raises the question if organisations and their practices are becoming similar across different countries or not (see e.g. Dewettinck and Remue, 2010). Based on the discussion of arguments for convergence and divergence, three key expectations emerge which are formulated into concrete propositions.

While the convergence perspective would suggest that organisations and their (HR) practices are becoming more alike across countries because organisations will respond to similar pressures in similar ways, the divergence perspective posits the opposite, namely that organisations and their HR practices tend to diverge from each other in significant ways or, at the very least, continue to exhibit similar degrees of difference (i.e. non-convergence) due to persisting national institutional differences.

As hospitals across Europe face similar generic pressures for improved performance, including financial pressures, technological and demographic changes and demands for accountability, it would be reasonable to suggest that this would lead to a shared and increased emphasis on performance and in turn PA cross-nationally, as suggested in **proposition 1** (Chapter 3). Overall, given the similar organisational/sectoral context (public hospitals) and pressures, it could be assumed that hospitals will adopt similar PA practices across countries and that this would result



in similar staff experiences and reactions to PA. The opposite perspective, reflected in **proposition 3**, would suggest that countries are embedded within their wider specific institutional setting which gives rise to distinct PA approaches. Thus, despite common pressures and an emphasis on organisational as well as individual performance, differences in the national context may mediate shared cross-national pressures, as depicted in figure 1, giving rise to differences in the extent to which, and the way in which, PA has been implemented and thus affected employees in different countries.

**Figure 1: Research focus**



More specifically, national differences regarding the industrial relations system, including collective bargaining arrangements and distinct roles for employee voice institutions, as well as differences in quality assurance mechanisms for healthcare, might give rise to distinct approaches to PA due to constraints on management choice. Yet, even national models of PA might still be permissive to variations, depending on the level of institutional or strategic leeway (Lange, 2009). By applying these perspectives to address the research questions presented above, this thesis investigates the extent to which these perspectives hold in relation to PA.

In addition, this thesis examines the interaction between employment relations institutions and the status of nursing. Within the chosen context of hospitals, a highly professionalised sector given that professionals represent a significant component of the care workforce (Kessler, Heron and Dopson, 2015), performance-orientated practices, and specifically PA, are often suggested to represent a tool for monitoring and control, which is deemed as generally problematic and professionals have been typically quite resistant towards such practices (e.g. Bezes et al., 2013; Demartini and Mella, 2013; Redman et al., 2000; Townley, 1997; Wilson and Cole, 1990). Indeed, the wider literature describes how implications of public management reforms informed by a managerial agenda can be mediated by the power of the profession (Ferlie, 1999; Farrell and Morris, 2003; Lapsley, 2008). Likewise, nursing, broadly categorised as a semi-profession, which implies that nurses across countries have now achieved “similar degrees of recognition” (Ayala et al., 2014, p.506), may not only moderate the impact of public management reforms but also of PA in similar ways across countries. These considerations are explored in **proposition 2**, against the backdrop of the professionalisation debate. It is argued that a *high* level of professionalisation among nurses, based on shared values and principles, leads to similar

approaches to PA in different countries. Furthermore, the argument is put forward that a *low* level of professionalisation instead provides scope for PA variation. Chapter 3 explores these potential outcomes in greater detail.

### 1.3 Research contribution

This study seeks to provide an in-depth understanding of PA practices in hospitals and the institutional factors influencing its practice, with a focus on nurses in the Czech Republic and Germany. By adopting an institutional perspective, this thesis first and foremost extends the conventional PA literature by examining how institutions shape the character of PA and how this, in turn, influences the consequences of PA. The need for an investigation of the circumstances under which PA is practiced and a greater focus on distal factors, such as those stemming from the national context, and how these influence PA, has been previously noted and indeed a range of scholars have called for more research on the wider context of PA (DeNisi and Murphy, 2017; Bretz et al., 1992; Murphy and Cleveland, 1991; Ilgen et al., 1993; Healy, 1997; Levy and Williams, 2004), especially regarding public sector organisations (Wang et al., 2017).

To do this, the present work builds on the existing PA literature to derive a framework for comparison which is utilised to compare PA approaches across countries. Thereby, the study enhances our knowledge regarding *why* PA is used, *how* it is introduced, and the *consequences* for nurses – a key occupational group in a sector that is rapidly changing. Furthermore, it provides a tool which may be used for comparative purposes in future studies on PA to explore the degree of similarity or difference.

The study benefits from taking a mixed-method comparative case study approach with a strong qualitative research component. Using this research design allows not only for an assessment of similarities and differences in relation to the different dimensions of PA but also an examination and determination of whether and how national institutions shape the character of PA and outcomes for nurses in public sector hospitals. Cooke et al. (2017) in their systematic review of cross-country comparative HRM studies, published between 2000–2014, found that 70 percent of studies were quantitative, while just 24 percent were qualitative and 6 percent used mixed methods. Consequently, there is an important opportunity to further our understanding of PA through a comparative perspective via mixed research methods, as it provides the scope for an in-depth and nuanced understanding supported by insights from both qualitative and quantitative data.

In this study, wider debates at the policy level and hospital reforms are explored to consider PA within its wider context via national-level stakeholder interviews and documentary evidence. By considering the specific national institutional setting and its impact on the workplace practice of PA, this thesis adds to the debate on the role of the institutional context and the dynamics between similarities and differences which is key to wider debates around convergence versus divergence. Workplace level data, including extensive interview and survey data as well as additional documents collected (e.g. workplace level agreements, guidance documents), particularly addresses the issue of the purpose of PA, the key features of PA and its consequences for nurses in detail, i.e. how they see the appraisal process and how they react to that process. In other words, if PA is perceived as a tool for managerial control which limits professional autonomy, do nurses resist its practice? If yes, in what ways? Or is PA a tool that can indeed be used to aid the nursing profession? Does it matter at all which precise form PA takes? Furthermore, this thesis investigates if and how the nursing profession can directly influence PA practices. As such, it uses PA as a lens to examine wider issues about the state of nursing as a semi-profession in two countries. In sum, the contribution of this thesis is focused on PA and a comparative analysis of nursing that sheds light on institutional differences within a broader context of hospital reform.

#### 1.4 Summary of findings

Findings from the first research phase (national-level stakeholder interviews and secondary statistical data) confirm that despite similar hospital pressures, which has contributed to an increase in PA in both countries, German and Czech hospitals differ in their dominant approaches to PA due to distinct institutional settings which shapes PA at local level. Detailed fieldwork at hospital level, which involved both qualitative and quantitative research methods, enabled a more thorough examination of the 'why', 'how' and 'what' of PA and the linkages between these dimensions. Despite some within-country variation, clear tendencies prevail in both countries. German hospitals exhibit more developmental and nurturing approaches to PA for nurses, whereas in Czech hospitals more control and judgment orientated approaches triumph. These tendencies can be ascribed to key national institutions in each case.

In the Czech Republic, the main driver for the introduction of PA is connected to external requirements associated with national hospital accreditation standards. This has clear implications for the main purpose of PA, which is to comply with these requirements. This affects the key features of the PA process so that it takes the form of a tick-box exercise. This in turn influences the way in which nurses perceive and react to PA. Although nurses generally accept PA, precisely because PA is known to be an external requirement and thus a legitimate necessity,

most nurses are dissatisfied with the PA system. Nurses can be observed to 'passively resist' PA in the sense that they comply, but only to a minimum extent, whilst grudgingly accepting the system and treating it as only a formality. However, this has little impact on the basic character of PA, which continues to be predominantly judgement and control-orientated.

In Germany, industrial relations institutions and especially the role of the works council (WC) was found to be the key national institution, capable of influencing PA practices considerably, given their strong co-determination rights. The collective bargaining agreement for the public sector (TVöD) is another relevant institution, as it sets out the scope for performance-related bonuses in conjunction with PA, and prescribes an important role for the WC in co-deciding if and how such an instrument should be implemented. WCs generally tend to resist control and discipline-orientated variants of PA, particularly coupled with performance-related bonuses, while being more neutral or supportive towards development and nurturing types of PA. Yet there is some scope for variation, depending on the stance of the particular WC, its relationship with hospital management and the hospital management's own strategy. The second German hospital case represents an exceptional case where PA was linked to individual performance-related bonuses, however only for a limited time, firstly, due to unintended consequences which emerged and, secondly, because the works agreement provided the scope for a move towards a team-orientated performance-bonus system associated with team-targets and developmental team meetings, and thirdly, due to the arrival of a new nursing director. These adjustments led to a more development-orientated approach to individual PA as well as team-level PA. Given the tendency for more development and nurturing types of PA in Germany, nurses reported that they perceive PA as an encouraging process wherein staff feels valued. Survey data confirms significant differences across the two countries in relation to key PA-related questions, including whether general nursing staff feels valued as a result of PA or not.

Despite some nuances in terms of specific developments within nursing which this thesis unravelled, in both countries nursing shares the status of a semi-profession, lacks a unified voice, a nursing chamber and political clout. Professionalisation via the academisation of nursing has not yet fully occurred in Germany and is planned to be reversed in the Czech Republic in an effort to counteract the nursing shortage, experienced in both countries, and due to the insistence of the medical profession. The lack of a united voice is also reflected in the diversity of professional associations, neither of which is found to actively engage with the topic of PA. Thus, nursing in both countries lacks the involvement and influence to directly shape PA from the outset through such nursing-related institutions. The key difference between the countries is that in Germany the WC compensates for nursing's limited influence in relation to PA.

## 1.5 Outline of the thesis

The thesis is structured as follows: After this introductory chapter, **chapter two** provides a review of the relevant research literature on PA to highlight the gap concerning the role of national institutional factors in shaping approaches to PA. It begins by defining the term PA and showing how the meaning of PA has evolved and become to be understood as an important component within performance management, as indicated by the increased use of the practice in the public sector. Subsequently, key PA literature are discussed and the main themes identified to derive at a framework for comparison. This study's contribution in this area is highlighted.

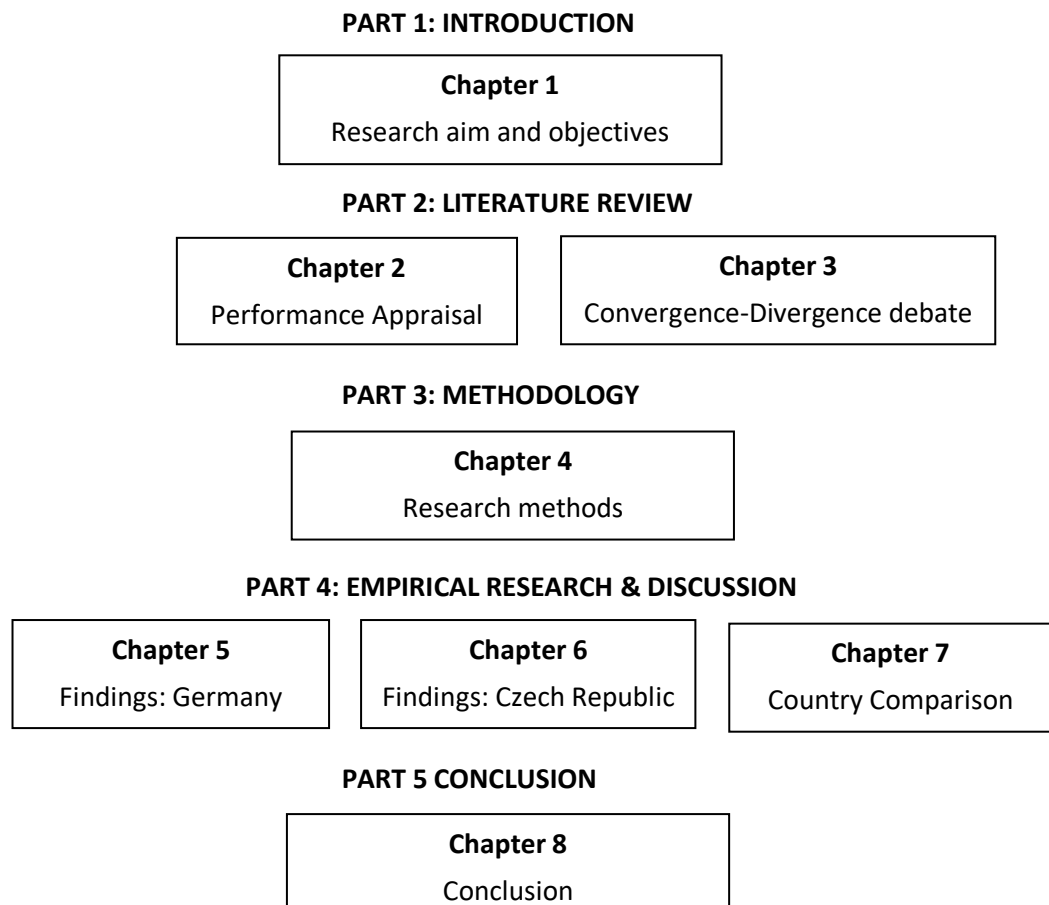
The **third chapter** centres on ongoing debates around convergence versus divergence in the wider literature and is divided into two main parts. The first part focuses on the convergence argument and the discussion of similar cross-national organisational pressures which would suggest that hospitals across countries will develop a shared emphasis on PA and ultimately adopt similar PA practices. It also considers the nursing occupation in more detail and its potential to contribute toward PA convergence. The second part discusses key concepts and variants in relation to 'institutionalism' and the role of national institutions in shaping organisational practices. Based on these considerations it is argued that shared pressures are moderated by national institutions leading to different approaches to PA. The possibility of within-country variation is also briefly contemplated. Finally, potentially relevant national institutions are explored, such as the particular healthcare and employment relations system and their role in contributing toward PA divergence.

**Chapter four**, begins by reiterating the theoretical basis of the study and the research problem and aim. Thereafter, the value of a comparative case study design is demonstrated. The rationale for the case selection and analysis is also discussed. Subsequently, the research methods adopted for this study are discussed. To do this, key research approaches in the social science are reviewed and the value of a mixed-method approach demonstrated. Then, the precise research methods for each question and at each level of analysis is further elaborated on. Finally, the researcher's comparative advantage is briefly commented on.

**Chapter 5 to 7** are dedicated to the discussion of the research's findings. Chapter 5 discusses the results of the German case. Chapter 6 presents the findings of the case-study research in the Czech Republic. Chapter 7 directly compares the cases and discusses its implications regarding the research questions and propositions posed.

**Chapter 8** concludes the thesis by providing a general overview of the thesis and highlighting its contribution and implications. Finally, limitations of the study are considered and potential routes for future research provided.

**Structure of thesis:**



## Chapter 2: Literature review: Performance Appraisal

### 2. Introduction

Having set out the research questions and main contribution in chapter 1, namely the investigation of how national institutions shape approaches to appraisal and their consequences, this chapter deals with the key topic of this thesis: 'performance appraisal' (PA). It has three main objectives: Firstly, to define 'performance appraisal' to enable effective comparison of this practice in different countries. Secondly, this chapter seeks to provide a brief overview of the key themes covered in the extant PA literature to show how this thesis adds to the existing body of knowledge. A general theme that runs through the chapter is that research on PA has so far largely ignored the role of the wider national institutional context, such as e.g. distinct national regulations, quality assurance arrangements of individual healthcare systems and industrial relations systems. This thesis aims to expand our understanding of the role of national institutional factors in shaping potentially distinct approaches to PA and, in turn, experiences and responses of nurses, a key occupation within healthcare. Previous research has demonstrated the importance of PA in the hospital sector and its wide-reaching implications in relation to patient care and reductions in patient mortality (West et al., 2002). Therefore, it is important to shed light on the constraints and opportunities stemming from the institutional context for different approaches to PA for hospital nurses.

Thirdly, building on existing research, a framework is developed for comparative purposes of PA practices across and within countries, and to facilitate the identification of institutional factors giving rise to either similarity or variation (i.e. convergence or divergence). This framework differentiates between four broad constellations or approaches to PA, each of which represents distinct main purposes [why] and key features of PA [how]. This in turn is suggested to lead to different consequences regarding the way in which nurses perceive and respond to PA. Each of the approaches is discussed respectively in separate sections concerning these three related dimensions, i.e. the 'why', the 'how' and consequences, drawing on relevant studies in this area. This chapter concludes by asserting how this research seeks to redirect and contribute to the research agenda that the studies reviewed here address.

## 2.1 The meaning of Performance Appraisal (PA): definition

Performance appraisal (henceforth: PA) is considered an important instrument in many organisations due to the potential performance implications at an individual as well as organisational level (e.g. DeNisi, 2000). At the most basic level, PA can be regarded as a regular, structured, formal communication process, typically between the subordinate and supervisor, concerning the employee's performance (Pearce and Porter, 1986). This is in line with Murphy and Cleveland (1995) who point out that PA is essentially a social and communication process that occurs in a well-defined organisational context.

Although PA is not a new concept and practice, its meaning and definition has evolved over time both in practice and within the academic literature. Traditionally, the term PA has been associated with the annual review of the subordinate's past performance in relation to objectives or criteria set by the manager. This conventional approach to appraising performance constitutes the filling out of an annual report and can be, but is not necessarily, complemented with a more or less formal discussion of the employee's performance, the appraisal interview (Fletcher, 2001). The nature of appraisal in this sense is largely top-down, whereby performance is judged by the supervisor/manager, i.e. it is being 'done' to the employee rather than constituting a two-way process.

PA has more recently become to be understood as part of a wider approach and is increasingly regarded as an important element of performance management (PM). The concept of PM can be regarded as a comprehensive strategic approach to integrating different yet interrelated HR activities, such as talent management, learning and development and reward management (horizontal integration) (Armstrong, 2009). The focus of PM is the performance of the organisation as a whole and the setting and measuring of *organisational* targets, as well as the linking of individual to organisational objectives (vertical integration) (Aguinis and Pierce, 2008). PM is based on the assumption that organisational performance is closely related to the performance of its individual staff members (Fletcher, 2001; Martinez and Martineau, 2001; Chiang and Birtch, 2010).

Thus, an important dimension of PM is PA which in turn is concerned with the performance at the individual level (Decramer et al., 2012; Armstrong, 2009). While appraisal used to be predominantly about past performance, within the context of PM, it is argued, the focus is more the future. In effect, the concept of PA has widened and become a general expression for a range of activities including those related to the assessment of staff and their performance, the



development of their skills and/or the distribution of rewards in order to ultimately improve performance (Fletcher, 2001; DeNisi, 2000; Wilson and Western, 2000).

While this thesis focuses on the PA instrument, it adopts this broader perspective in terms of purposes of PA, as a crucial element of PM. This means that PA is not necessarily solely used as a mechanism for evaluating/appraising past performance but a wider approach which can constitute various purposes, including e.g. feedback and goal-setting and e.g. planning, managing, rewarding and/or developing performance and can thus be past, present and/or future-orientated (Krausert, 2009; DeNisi and Murphy, 2017; Ikramullah et al., 2016). PA can also relate to teams rather than just individuals (Krausert, 2009; Scott and Einstein, 2001). This perspective acknowledges that there is scope for different variants or approaches to appraisal. Hence, there are several objectives PA systems might pursue, such as evaluation and/or development, which affects the basic character of PA, discussed in the following sections.

The next section begins by briefly examining the wider PA literature and the emerging main themes and research gap. Then, the framework for comparison and the varying PA approaches are presented, each of which signifies different purposes ['why'], key features ['how'] and consequences.

## 2.2 Main themes within the PA literature

PA is a widely-debated topic and has been studied from a variety of viewpoints. Research on PA spans over several decades and more (Denisi and Smith, 2014; DeNisi and Murphy, 2017). Despite the vast literature that exists, PA continues to be an important research area firstly, because of the importance attached to PA in relation to its effect on employees and potential for improved performance (both at the individual and organisational level) and secondly, due to largely unexplored research areas which still remain, such as the impact of national institutional factors on PA (DeNisi and Pritchard, 2006; DeNisi and Smith, 2014; Kline and Sulsky, 2009; DeNisi and Murphy, 2017).

It is possible to distinguish between two main perspectives in relation to PA. Firstly, the conventional stream of PA research represents the more traditional managerialist critique which is primarily concerned with the design of a particular PA system (Bach, 2005, 2013). Whilst this perspective recognises some of the practical issues of PA (e.g. in terms of accurate ratings etc.), it considers how these can be minimised to allow for an effective application of PA (Winstanley and Stuart-Smith, 1996; Prowse and Prowse, 2009). An important aspect or theme here is also the distinction between PAs concerned primarily with evaluation versus those mainly concerned with staff development. It is suggested that for PA to be effective, these two functions should

be separated from one another due to the inherent conflict between these two purposes (e.g. Boswell and Boudreau, 2002; Wilson and Western, 2000; Murphy and Cleveland, 1995).

The second strand of research relates to what is often called the 'radical critique' of PA (Bach, 2005, 2013; Winstanley and Stuart-Smith, 1996; Prowse and Prowse, 2009) which regards PA as an inherently controlling and therefore problematic tool given the ethical concerns this raises (e.g. Newton and Findlay, 1996; Healy, 1997; Townley, 1989; 1993a; Grey, 1994). Under this perspective, increased managerial control is often associated with a concomitant decrease in professional autonomy. Because of the highly professionalised nature of the public sector, PA research conducted in this area has often adopted this perspective and emphasised the control function of PA and interpreted PA as a threat to professional autonomy (e.g. Townley 1993b; Healy, 1997; Newton and Findlay, 1996; McGivern and Ferlie, 2007; Coates, 1994). Thus, another central emerging theme, especially evident within this strand of PA research, concerns the extent to which PA serves as a tool to increase managerial control or leaves room for professional autonomy (Simmons and Eades, 2004).

Both these perspectives are useful in that they provide an insight into the potentially distinct character and associated purposes of PA systems, as further discussed below. In the following section, first the traditional PA literature is reviewed and then the dominant theme in relation to 'judgement/evaluation versus development' within this strand of literature highlighted. Thereafter, the radical critique is briefly expanded on to further demonstrate the theme of 'control versus professional autonomy'. The third perspective, which suggests that PA is essentially a ritualistic practice whatever precise form it takes, and thus not impactful, is also acknowledged. This thesis draws on the dimensions these contributions raise to develop a framework for the comparison of PA approaches in different settings.

### 2.2.1 Traditional PA literature

As highlighted above, an evolution can be detected regarding the meaning of PA from a process primarily associated with the formal monitoring and evaluation of employees' performance to denote a wider-reaching process. The beginnings of this evolution can be traced back to the early 1990s (Murphy and Cleveland, 1991; Ikramullah et al., 2016), however, only more recently is PA considered an important part of PM (DeNisi and Smith, 2014; DeNisi and Murphy, 2017). Despite this development, the tendency in the wider literature is still to view PA primarily as a tool which seeks to measure employees' past performance levels via ratings rather than a tool which can serve various purposes (see e.g. Djurdjevic and Wheeler, 2014; Cappelli and Conyon, 2017). This is reflected in the fact that PA is frequently still referred to as 'performance review' or 'performance evaluation' (see e.g. Rynes et al., 2005; Ferris et al., 2008).

This occurrence has historical dimensions. According to reports, the practice of PA has probably first been applied in an industrial context in the form of merit rating in the early 1800s at a large textile mill in Scotland (Wren, 1994; Murphy and Cleveland, 1995; Wiese and Buckley, 1998; Prowse and Prowse, 2009). In the US, the start of formal PA is usually traced back to 1813 to an Army General who undertook evaluations of his subordinates. The US Federal Office reportedly adopted initial forms of merit or efficiency ratings in the late 1800s (Murphy and Cleveland, 1995; Wiese and Buckley, 1998). According to Wiese and Buckley (1998) it is no surprise that PA was mainly used in government organisations and the military in the late nineteenth and early twentieth century because of the size, hierarchical nature and geographical dispersion of such organisations which requires PA, and to identify top performers for promotion. A further key impetus for the wider introduction of PA in the US Army in World War I, and then around World War II, has been associated with the work of industrial psychologists and trait psychology (Murphy and Cleveland, 1995). This interest in PA then spread to business leaders, so much so that by the 1950s PA was a widely accepted practice in organisations (Murphy and Cleveland, 1995). This resulted in further research on PA by psychologists, the development of the graphic-rating scale (Landy and Farr, 1983) and eventually more work on rating scales and techniques such as behavioural anchored rating scales, behavioural observation scales and later results-orientated approaches like management-by-objectives alongside forced distribution of rankings (Wiese and Buckley, 1998; Prowse and Prowse, 2009).

This historical background of PA, and its roots in the psychological tradition, means that the scope of PA research has often been quite narrow because it focuses on rating and evaluation-related issues (Brutus, 2010). Special attention has been paid to the design of rating scales and training programmes for raters/appraisers (see review by DeNisi and Smith, 2014). In particular, much research has been devoted to ways in which rating errors can be eliminated or how rating accuracy can be improved. The emphasis of PA as a measurement problem was particularly pronounced up to the 1980s (Landy and Farr, 1980). Yet, research efforts throughout the 1980s and beyond continued to focus on rating accuracy albeit in relation to rater cognitive processes, i.e. ways in which managers form judgements, as well as issues relating to biases in appraisal (see e.g. Roberson et al., 2007; Brutus, 2010).

Overall, psychometric and cognitive research has long dominated PA research, as summarised in table 2.1, with many authors pointing to the excessive focus on measurement and rating issues (e.g. DeNisi and Pritchard, 2006; Murphy and Cleveland, 1995; Balzer and Sulsky, 1990; Whiting et al., 2008; Ferris and Treadway, 2012; Haines III and St-Onge, 2012).

**Table 2.1: Summary of main themes covered by the performance appraisal literature**

	<b>Main themes</b>	<b>Key References</b>
1950s-1980s	PSYCHOMETRIC RESEARCH improving instruments used in making performance ratings; advantages and disadvantages of different types of rating scales	Landy & Farr (1980, 1983); Feldman (1981)
1980s-1990s	COGNITIVE RESEARCH Way in which raters form judgments of their subordinates' performance; information processing in PA; rater characteristics; cognitive process issues	DeNisi (1997); Ilgen et al. (1993); Bretz, Mikovich, & Read (1992)
Since 1990s	SOCIAL CONTEXT RESEARCH i.e. the rating environment or 'social milieu' within which appraisals take place, e.g.: Rater motivation of raters; individual differences; rating purpose; ratee motivation; ratee participation; ratee reactions	Murphy & Cleveland (1991); Ilgen et al. (1993); Levy & Williams (2004)
Since 2000s	INCREMENTALLY BROADER FOCUS 'proximal' factors (e.g. feedback environment; relationship between appraiser and appraisee; 360-degree PA); 'distal factors' (e.g. technological environment and impact on PA; cultural differences in PA) PA as part of HRM 'bundles' (i.e. HPWP) and relationship with firm-level performance; PA as part of PM in public sector	DeNisi & Kluger (2000); Levy & Williams (2004); DeNisi & Pritchard (2006); Bach (2012); DeNisi & Smith (2014); Djurdjevic & Wheeler, 2014; DeNisi & Murphy (2017)

Source: Author compilation

Since the 1990s researchers have called for more research on the social context within which appraisals take place, also referred to as the social milieu, rating environment or socio-organisational context (Bretz et al., 1992; Ilgen et al. 1993; Levy and Williams, 2004; DeNisi and Smith, 2014). The notion of 'social context' encompasses both 'distal' factors and 'proximal' factors affecting appraisals and those individuals involved in the PA process. Distal factors essentially relate to the organisational context (e.g. organisational structure, culture and goals; technological environment) and/or the wider national institutional context (e.g. national legal environment, national industrial relations system/ collective bargaining arrangements) while proximal factors are those which make up the immediate PA context and have a more direct relation either to the process of PA (e.g. feedback environment; relationship between appraiser and appraisee) or the structure of PA (e.g. performance rating criteria used, frequency of PA) (Levy and Williams, 2004; Djurdjevic and Wheeler, 2014). It is these proximal factors which have been the focus of much of the PA research more recently in stark contrast to the distal factors, and specifically national institutional factors, which have been largely ignored (Djurdjevic and Wheeler, 2014).

Overwhelmingly, research has concentrated on proximal issues such as in terms of rater/appraiser and appraisee motivation, individual differences and the supervisor-subordinate

relationship. A major research area more recently regarding proximal factors relates to 360-degree (i.e. multi-source) feedback, as also highlighted in table 2.1, which implies drawing on a variety of rating sources (e.g. customers subordinates, peers) to increase rating validity. Another important area relating to proximal factors relates to the appraisal purpose as well as appraisee reactions to the PA process (see Levy and Williams, 2004; Pichler, 2012). Indeed, a great deal has been written on PA and its purposes (Boswell and Boudreau, 2002). Given the traditional focus within the PA literature on rating issues and cognitive processes, research has shown that the purpose of PA can affect ratings, behaviours of raters and the overall effectiveness of the PA system (Murphy and Cleveland, 1995; Cleveland, Murphy and Williams, 1989; Boswell and Boudreau, 2002; Williams, DeNisi, Blencoe and Cafferty, 1985). In the following the two dominant purposes for PA, which emerge from this strand of literature, are considered as this is an important consideration in relation to the possible distinct approaches to PA.

### *Judgement vs development*

As the broader definition of PA suggests, PA can serve several different purposes (Murphy and Cleveland, 1995; Fletcher, 2001). Based on the wider literature Cleveland et al. (1989) identified 20 reasons for why PA is used. The most important are: retention or termination, salary administration, recognition of individual performance and identification of poor performance; identification of training needs and the strengths and weaknesses of individual employees; feedback; determination of assignments; reinforcing authority structure; meeting legal requirements. However, the dominant distinction made in the traditional literature is between PAs which are primarily concerned with *development* versus PA systems which focus on *evaluation/judgement* (e.g. Boswell and Boudreau, 2002; Simmons and Eades, 2004; Poster and Poster, 1993; Meyer et al., 1965; Reinke, 2003; Moussavi and Ashbaugh, 1995) and it is suggested that most uses of PA can be at least broadly categorised under either the main purpose of development or evaluation/ judgement.

Whilst arguably in both cases the ultimate, overarching aim of PA is to manage and improve individual performance and by extension organisation performance (Brown et al., 2010), the focus lies on different aspects: 'development' is mainly concerned with the individual and improving his/her ability to perform well in their current or any future roles by providing and identifying personal development opportunities; 'judgement' focuses on the task or performance itself and the evaluation thereof, in many cases in order to make administrative decisions on the basis of this evaluation (Poster and Poster, 1993).

Several authors argue for the separation of summative (assessment/judgement) and formative (development) objectives in PA because it is argued that these two orientations or purposes are so inherently different in nature that they are incompatible (e.g. Boswell and Boudreau, 2002; Wilson and Western, 2000; Barge, 1989; Meyer, Kay and French, 1965; Murphy and Cleveland, 1995; Taylor et al., 2002; Zedeck and Cascio, 1982). More specifically, it is argued that the combination of PA as a developmental tool and PA as a tool to judge for example to determine rewards is problematic, given that this requires the appraiser to perform two conflicting roles, namely that of a judge and a helper. This indicates the problematic 'split roles' in PA, when PA is used on the one hand to determine key outcomes such as pay (through evaluation) and on the other hand is supposed to motivate employees to improve (through development) (Meyer et al. 1965), which can be said to constitute conflicting objectives (Cleveland, Murphy and Williams, 1989; Meyer et al., 1965; Taylor, 1998; Newton and Findlay, 1996). Hence, it is suggested that PA should focus on either one or the other or that these purposes should be pursued in different processes (Boswell and Boudreau, 2002). In comparison to the radical critique, discussed in the next section, the traditional critique recognises that, despite possible 'dilemmas' (Wilson, 2002), PA has the potential to be set-up in a way that benefits both the organisation and employee which prerequisites that the incorporation of conflicting purposes is minimised.

Again, the traditional PA literature points to the importance of distinguishing between judgement versus development. The next section considers the radical critique and its main theme of 'control versus autonomy'. This thesis argues that these dominant distinctions are key to be able to understand and effectively compare PA approaches in different contexts.

### 2.2.2 'Radical' perspective

The key difference between the traditional strand of the PA literature and the 'radical' perspective on PA is that the former is more optimistic in terms of minimising the limitations of PA at the implementation stage and thereby increasing the effectiveness of PA whereas the latter regards PA as doomed due to its connotations with control (e.g. Bach, 2005). Thus, the radical critique is an important strand in the PA literature which highlights the use of PA as a control or monitoring device with an emphasis on discipline and surveillance and a concomitant decrease in professional autonomy (e.g. Townley 1993b; Healy, 1997; Newton and Findlay, 1996; McGivern and Ferlie, 2007; Coates, 1994). This view is particularly highlighted in PA research which focuses on the public sector, including the hospital sector, given the highly professionalised nature of this sector and the occupations that work within it, including nurses (Northcott, 1997).

In general, most research conducted on PA tends to focus on the private sector (Kim and Holzer, 2016), although PA research within the public sector is increasing, as indicated in table 2.1 (see e.g. Oh and Lewis, 2009; Weibel et al., 2010; Brown, Hyatt, and Benson, 2010; Azzone and Palermo, 2011; Linna et al., 2012). This coincides with the fact that the incidence of PA in the public sector has reportedly increased under the influence of so-called 'new public management' reforms in a quest for higher efficiency and more accountability (Decramer et al., 2012; Martinez, 2001; Perrin, 1998), specifically also in healthcare, which is often associated with a threat to professional autonomy (Brunetto and Farr-Wharton, 2004; Bolton, 2004; McGivern and Ferlie, 2007). These general pressures affecting hospitals, and how this may affect PA, are discussed in the next chapter.

As this thesis focuses on nurses working in public sector hospitals, the theme of PA as a tool for control or alternatively a tool which provides scope for professional autonomy is highly relevant for this study and needs to be considered in any assessment of the influence of national institutional factors on the nature of appraisal in the hospital setting.

#### *Control vs. professional autonomy*

Whilst it is acknowledged that aspects of PA can differ across organisations at least to some extent, e.g. in relation to the details of the PA system, the radical critique considers PA essentially and inherently as a managerial activity and tool for controlling employees. Again, this is regarded as problematic and to be at odds with autonomy traditionally granted to professionals (e.g. Newton and Findlay, 1996; Healy, 1997; Townley, 1989; 1993a; Grey, 1994). Indeed, previous research has categorised PA as an important control mechanism (Eisenhardt, 1985; Ouchi and Maguire, 1975) and stressed the monitoring aspect and the managing of employees' behaviours as a central theme of PA systems (Ferris and Treadway, 2012; Brown and Heywood, 2005) and even equated PA as a "mechanism of managerial power, a mechanism of visibility and surveillance, a technique of discipline" (Wilson, 2002, p. 621).

At the same time however, other scholars taking a more balanced position, while also critical of the potential control element within PA and its use as a bureaucratic control device are more receptive to the possibility of a more suitable, 'professional' type of PA (e.g. Fitzgerald et al., 2003), namely one that is developmentally-orientated. Specifically, in the hospital context, evidence has shown that effective PA characterised by a focus on communication, feedback and development is associated with improved patient care and reductions in patient mortality (West et al., 2002) and is ultimately recommended to enhance public protection (Francis, 2013). At the individual level, it is suggested that the practice of PA can help to alleviate stress in the

workplace for nurses (Wright, 2014), *can* help motivate nurses (Baard and Neville, 1996) and *can* even create trust and a sense of purpose for nurses within the workplace (MacKenzie and MacKenzie, 1995). However, it is also noted that the potential of PA is not always exhausted and instead remains a highly unpopular practice (e.g. Cappelli and Conyon, 2017) and a challenge for organisations (Keizer, 2011).

Apart from the traditional PA literature and the critical literature which regards PA essentially as a control mechanism, McGivern and Ferlie (2007) identify a third perspective, namely which views PA largely as a ritual without any real impact at all (e.g. Barlow, 1989; Armstrong and Murlis, 1998; Chamberlain, 2010) because those who practice and experience PA tend to view it as a ritualistic, time consuming and overall an unproductive practice (Cousins, 1995; Darling-Hammond, 1990; Grint, 1993; McLaughlin, 1990) regardless of the precise type of PA. Despite its inefficiency, PA is 'tolerated' if it does not constrain any activities (McGivern and Ferlie, 2007). On the whole therefore, the radical perspective and its high concern with managerial control and its threat to professional autonomy may be criticised, as well as the traditional perspective, on the basis that in many cases the form PA takes may be irrelevant as it largely represents a ritualistic event. However, even PA practices which are perceived as a ritual and tick-box exercise may be argued to have problematic implications in terms of satisfaction with the PA process.

Overall, although there is a general acknowledgement that the use of PA has increased substantially in recent years and has been extended to larger parts of the workforce not traditionally covered by PA, including professional staff (Keizer, 2011; Krausert, 2009; Prowse and Prowse, 2009), it is not clear if PA is being used in similar or different ways in hospitals across and within countries, why either similarities or differences prevail, and what the outcomes are for nurses in practice. Specifically, in the context of public sector organisations the need for more cross-national comparisons and research on the impact of national-level contextual factors in relation to PA is stressed (Wang et al., 2017). The following section further elaborates on this research gap and highlights notable exceptions.

### 2.2.3 Research gap

Despite advancements in the literature in relation to the proximal aspects of PA, such as the purpose of PA, we know very little about how more distal factors influence the approaches to appraisal (DeNisi and Murphy, 2017; Djurdjevic and Wheeler, 2014; Levy and Williams, 2004), stemming from the national institutional context, such as e.g. the industrial relations system, national quality assurance systems and labour laws. In particular, little is known about which and how such broader factors shape the purpose of the PA system in the first place and how this



in turn affects the nature of PA. Neither the more traditional nor the more critical PA literature addresses the extent to which similarity or variation can be identified across countries, and how these macro-level factors which make up the national context shape the experiences of PA at local level.

These questions remain largely unanswered because much of the research on PA has been “decontextualized” (DeNisi and Murphy, 2017, p.129) focusing on individual aspects of the PA process separately and in isolation of context. Therefore, the need to put PA into context is emphasised which involves the investigation of the circumstances under which appraisals are introduced and practiced (DeNisi and Murphy, 2017). Indeed, it is vital to contextualise research, particularly via comparative studies, to be able to identify the impact contextual factors have on the phenomena under investigation (Johns, 2001, 2006; Rousseau and Fried, 2001). The PA literature is often criticised for not taking a holistic view, i.e. only certain aspects of the PA process are examined rather than considering the PA process as well as outcomes within the wider context. A holistic approach to studying PA is therefore advocated (Djurdjevic and Wheeler, 2014; Ikramullah et al., 2016; Festing and Knappert, 2014) whereby the PA process is regarded as a whole and within its broader context.

Exceptions include studies that have investigated and confirmed the impact of national culture on PA, frequently using Hofstede’s (2001) national dimensions and often focusing on MNCs (e.g. Peretz and Fried, 2012; Chiang and Birtch, 2010). These studies are useful in that they indicate the importance of aligning PA systems within the broader cultural context they are situated in (e.g. Peretz and Fried, 2012), however, the focus in these studies is solely on national culture to the exclusion of other institutional factors and is thus limited in its perspective. This limitation manifests itself in findings which indicate that differences in PA practices exist between countries which however have similar national cultures (Chiang and Birtch, 2010) and suggestions that institutional factors have greater explanatory power than cultural factors (Brookes et al., 2011; Maley, 2013). The precise definition of ‘institutions’ is further considered in chapter 3 in the discussion of the contextual perspective (section 3.2).

Nevertheless, another exception includes the discussion paper by Festing and Barzantny (2008) who take not just national culture but a whole set of national factors/institutions into consideration which may impact PA practices such as the role of the state, national (labour) legislation, labour markets, collective bargaining arrangements, education and training. Festing and Barzantny (2008) specifically focus on Germany and France and indicate the importance of investigating the role of specific national institutional factors, especially co-determination rights of WCs in Germany which they argue contributes to more development and training orientated

uses of PA in comparison to France. However, their focus is on multinational corporations and does not provide any empirical evidence due to being a theoretical piece. Only a footnote indicates that their analysis was “corroborated with several interviews of HRM professionals of MNCs (...)” (p. 227).

Festing and Knappert (2014) however, using a quantitative approach, examine similarities and differences with respect to various features of the “PM system”, which essentially implies PA systems in this case as per the definition provided above. Based on 167 completed surveys by managers in the subsidiaries of one MNC in three countries (Germany, United States and China) they find that significant differences solely emerged on 6 of 16 investigated features. Yet again, this research has several limitations. Apart from the small sample size, it does not explore why these similarities or differences occurred and only focused on one company. Overall, the literature on PA as well as PM more broadly continues to lack both empirical and conceptual research regarding the influence of national institutional factors whilst the national cultural dimension has received more attention (Festing and Knappert, 2014), as indicated in table 2.1.

Since the conventional literature on PA tends to concern itself with micro-level issues to the exclusion of the wider national context, this research seeks to enrich the PA literature by examining whether institutional differences give rise to distinct PA approaches across countries and to what extent there is still discretion within countries to adopt varying PA practices, or, alternatively, whether common hospital pressures override these differences, leading to similar PA approaches.

It is important to further our understanding of the potential constraints and/or opportunities stemming from the institutional context for different approaches to PA since PA can have significant implications not just for the workforce but in the case of hospitals also the quality of care and patients (West et al., 2002). Therefore, it is crucial to understand which broader factors lead hospitals to introduce specific types of PA and for which purposes, and how this in turn shapes the PA process and consequences.

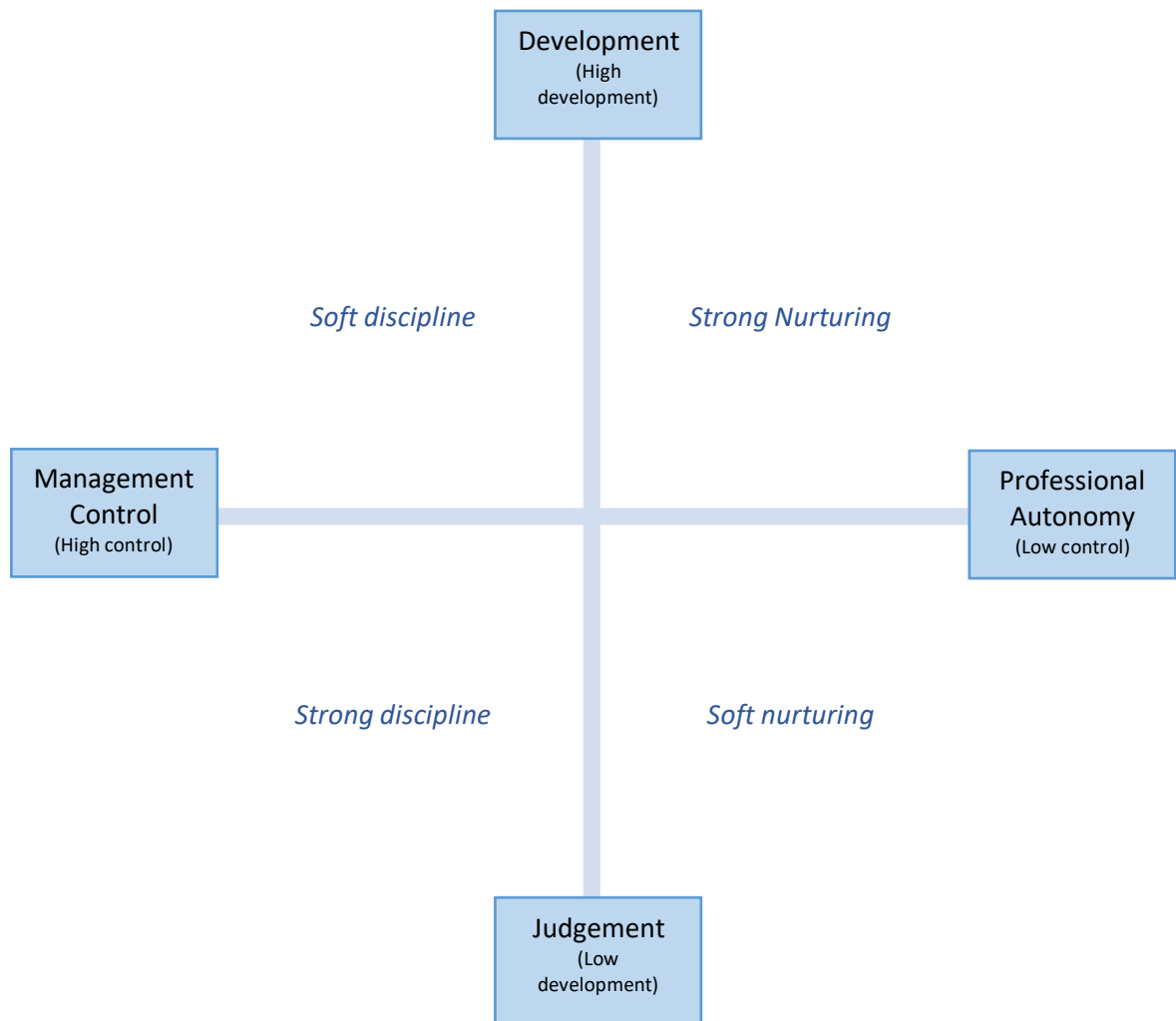
To be able to effectively compare potentially distinct approaches to PA and identify the extent to which convergence or divergence can be identified, in the following section, the framework for comparison is introduced which suggests that, based on the themes identified above (judgement vs. development and control vs. autonomy), there are different forms PA can take. This framework is developed because the literature lacks a suitable typology by which to classify different types of PA and explore the degree of similarity and difference of various PA approaches.

### 2.3. Approaches to performance appraisal: Framework for comparison

The wider PA literature and contributions from the 'managerialist' and 'radical critique' perspective respectively raises important dimensions. By drawing on these dimensions, a framework is developed with the aim of enabling comparison of approaches to PA. This thesis thus draws on this earlier work to derive a framework, however, does not seek to clearly categorise these contributions within this framework given that such a classification is not straightforward, especially retrospectively.

The framework for comparison presented here reflects the two main themes which emerge from the literature in relation to the extent to which PA is used a) for development versus judgement/evaluation and b) as a tool for control versus a tool which provides room for worker autonomy. These two themes reflecting the main distinct purposes of PA, and the concomitant tensions between them, are illustrated in the framework for comparison in figure 2.1 and are suggested to result in four broad constellations or variants of PA. As demonstrated in figure 2.1, PA can on the one extreme be either judgement and control-orientated (strong discipline) or alternatively mainly developmental whilst nurturing within a context of professional autonomy (strong nurturing). This is reflective of so-called hard vs. soft approaches to HRM. For example, Nickson (2007) differentiates between hard and soft approaches specifically in relation to PA, with 'harder' approaches being brought into connection with organisations seeking control over their employees and the 'softer' ones associated with organisations seeking to develop their employees and establish greater commitment (Nickson, 20007; Myers and Krik, 2009). While for each type of PA other factors may affect the quality of PA (e.g. ability of subordinate to carry out PA effectively), resulting in quality differences in PA systems, it is argued here that the purpose of PA has clear implications for the format of PA which largely determines the nature of PA and which, in turn, leads to dominant consequences.

**Figure 2.1: Framework for comparison: Performance Appraisal**



Source: Author compilation

As mentioned above, several authors argue for the separation of objectives in PA related to judgement and development (e.g. Boswell and Boudreau, 2002; Wilson and Western, 2000; Barge, 1989; Meyer et al, 1965; Murphy and Cleveland, 1995; Taylor et al., 2002; Zedeck and Cascio, 1982). However, it is also acknowledged that in practice such a separation is often hard to achieve as there is no other instrument to turn to. Hence, PA systems can encompass multiple even contradictory purposes (Wilson and Western, 2000; Cleveland et al., 1989). As the wider literature on PA suggests, the kind of PA adopted is not necessarily either 'developmental and nurturing' or a simple matter of 'control' (Bolton, 2004), as depicted in the framework (figure 2.1), which is why a more critical engagement with the literature is needed. In other words, tensions between the purposes (the extent to which PA is used to increase managerial control vs the extent to which PA is concerned with development) can exist however to different

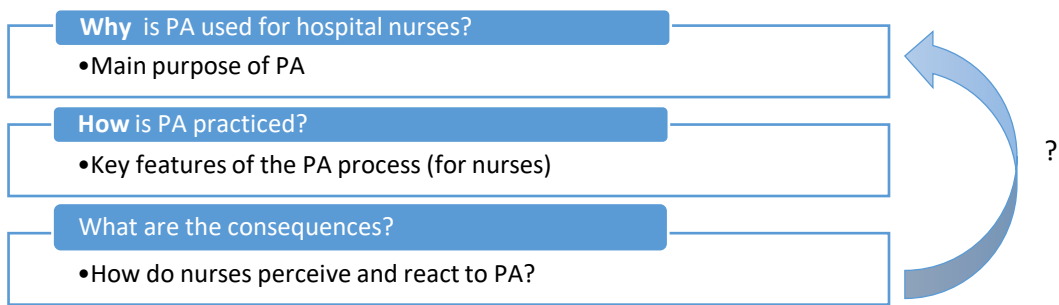
degrees, depending on the exact emphasis placed on the various aspects of PA. Therefore, it can be suggested that there is the possibility of 'hybrid' forms of appraisal. As described below, combinations are possible where, for example, judgement is present but together with a high degree of discretion sensitive to professional autonomy (soft nurturing). Another possible variant is where PA is both control and development-orientated at the same time (soft discipline).

The framework for comparison indicates that PA can pursue different purposes which affects the overall nature of PA and can constitute tensions between these purposes. It is also important to note that these approaches to PA represent broad categorisations and that PA systems may have elements of different aspects reflected in each PA 'type', therefore it is not simply a matter of four discrete versions of PA. However, such a framework is useful to illustrate the main themes apparent in the literature and to show that 'hybrid' forms of PA (i.e. combinations) are possible. The framework established for this study concentrates on the two major themes identified above, which are further discussed with respect to the emerging different combinations, as these are particularly relevant in relation to the public-sector context.

Each of these approaches to PA is argued to constitute different purposes [why], formats [how] and to furthermore result in different outcomes or consequences for nurses. These three aspects in turn represent the dimensions for comparison in this thesis, illustrated in figure 2.2. Again, while the possibility of quality differences in the PA process should be acknowledged (i.e. the way PA is conducted by individual managers), it is argued that the purpose (why) and the key features of PA (how) will set the fundamental parameters of any PA system and thus affect the basic character of PA, including the general quality of a specific PA system (which may be influenced by e.g. the degree of structure provided or pre-determined ['how']), and thus its consequences. The insights gathered with respect to the why, how and consequences of PA from the literature, reviewed next, is summarised in table 2.4 at the end of this chapter.

The next three sections are concerned with these three dimensions, namely the why, how and consequences for each of the distinct approaches to PA respectively. These sections draw on the wider PA literature, however where possible relevant studies in the context of the public sector are highlighted. Again, it is shown that research has largely ignored how national institutional factors may affect the purpose, overall character and consequences of PA.

**Figure 2.2: Dimensions for comparison**



Source: Author

### 2.3.1 The 'Why': Main purposes of appraisal

The purpose attached to PA is often highlighted as crucial, as there is a general recognition that the main purpose of PA has implications for the PA system as a whole, i.e. the way it is set-up, the procedures it involves and its practice, as well as the extent to which PA itself is accepted by the workforce (Ikramullah et al., 2016; Maley, 2013; Kim and Holzer, 2016). These issues are discussed further below in relation to the 'how' and 'consequences'. This section looks at each of the approaches to PA identified above in relation to their main purposes [why], with reference to relevant studies.

#### *Strong discipline: Judgement & Control*

Where the main purpose is the evaluation of performance, the onus lies on judging the individual employee and measuring their performance on the basis of set performance criteria to ensure staff are carrying out their work tasks as prescribed (Martinez and Martineau, 2001). This purpose of PA reflects the traditional definition of PA as an essential tool for monitoring and measuring performance. Often, PA in these cases is connected to decisions in relation to e.g. pay increments, performance-related pay or bonuses and can even be connected to promotion or demotion, i.e. administrative decisions (Boswell and Boudreau, 2002; McGovern et al., 2007; Gifford, 2016). This implies that the judgement of performance serves to reward or discipline the individual in question financially or otherwise depending on the performance levels achieved, as judged by the appraiser. As such, PA can also involve punitive, disciplinary measures (Nickson, 20007) and in extreme cases be used for decisions in relation to redundancy (Boswell and Boudreau, 2002; Wilson and Western, 2000). These purposes of PA strongly resonate with the 'judgement' type of PA as identified by Poster and Poster (1993) where "managerial authority" is assumed "to make judgements" and PA is ultimately used to "maintain social control" (p.9).

Thus, as can be seen, the function of PA as an evaluative tool strongly relates to the notion of attempting to 'control' performance and by extension the individual who is being appraised. Professionals have traditionally been granted a high degree of autonomy and professional power (Freidson, 2001; McGivern and Ferlie, 2007). The incorporation of judgemental forms of appraisal in the public sector as well as the greater emphasis on accountability (Cohen et al., 2002), specifically in the healthcare context, is often associated with a challenge to professional autonomy via increased managerial control. This version of PA is thus broadly in line with the radical critique of PA, discussed above.

For example, Townley (1993b) analyses PA systems through appraisal-related documents in 30 UK universities, although not the actual practice of PA, and concludes that PA functions like a panopticon, a metaphor originally put forward by Foucault (1995) to describe asymmetric power relations, surveillance, disciplinary power, and the internalisation of this surveillance, perceived constant visibility and discipline. Likewise, PA is argued to require continuous monitoring and indeed surveillance. The appraiser must adopt a predominantly judgemental role while also being subjected to judgement, surveillance and control. Moreover, PA is found to be disciplinary in nature. Appraisals are used as an exercise of managerial power and is part of the disciplinary apparatus available to management (Townley, 1990; 1997).

Coates' (1994) case study, which includes interviews with 'white-collar' staff at a trust hospital in the UK is used to illustrate the core purpose of the PA system, namely the seeking of control and compliance of those being appraised. Again, the focus of PA is found to be on making judgements and conducting assessments. In line with a Foucauldian perspective, the metaphor of appraisal as a 'panopticon' is used to make the case of PA as a tool which seeks "subordination through surveillance" (p. 185). It is concluded that not only does PA serve to ensure discipline and heightened organisational control, but through PA the normalisation of certain behaviours can be steadily monitored and reinforced (Coates, 1994; 2004).

Finally, Healy (1997) looks at the education sector and analyses schoolteacher appraisal through documentary, quantitative and qualitative data and illustrates the tensions in the prominent discourse between control and professional development. Moreover, teacher appraisal is placed within a wider historical context and wider trends in the sector including the drive for accountability, marketisation and managerialism. The role of trade unions is also considered who regard PA as a managerial control tool rather than a tool for enhancing professionalism as which it is being 'sold'. So, although the purpose of PA is presented as enhancing professionalism through development as associated with 'soft' HRM, in reality the purpose identified by Healy (1997) is that of discipline and control. Indeed, Healy (1997) finds that

appraisal serves to strengthen managerial control and reinforces managerial power and patronage.

The key point of these studies is that in the public-sector context PA systems, which are often introduced to create and demonstrate accountability, invariably challenge professional discretion and autonomy and are therefore regarded as largely inappropriate in such organisations. Healy's study is useful because, by taking an 'industrial relations perspective', it takes the specific context within which PA is implemented and some of the drivers into account, however falls short in terms of considering how the role of trade unions in other (national) contexts may or may not result in the adoption of different kinds of PA systems for different purposes. On the whole, these studies largely ignore the possibility of intervening national institutional mechanisms which allow for other, more nurturing 'types' and purposes of PA to dominate, such as the role of WCs.

#### *Strong nurturing: Development & Autonomy*

This variant of PA echoes the rhetoric in the wider prescriptive HRM literature about a developmental orientation which 'promises' a committed, motivated and productive employee (Hoedemaekers, 2009, p. 192). Within the PA literature specifically, there is a trend to highlight the benefits of developmental PA in relation to increased motivation, commitment and ultimately work performance (Kuvaas, 2007). In their extensive literature review Posthuma and Campion (2008) identify best practices for PA and suggest that at the implementation phase PA should be developmental. Similarly, Martinez and Martineau (2001) argue that the most promising or successful approaches to appraisal are characterised by a focus on development. General guidelines by e.g. the CIPD (2017) emphasise the importance of engaging in a dialogue not just about employee performance but particularly also developmental opportunities and about ways to support the employee to fulfil his/her role.

While it is acknowledged that even development-orientated PA can have or even requires elements of evaluation and judgement in relation to the assessment of the individual's strength and weaknesses (Boswell and Boudreau, 2002), the emphasis within this evaluation is argued to be different in nature in such development-orientated approaches. Related to the main purpose of development, the focus is on positive supervision and helping the individual through the identification of training needs and other developmental initiatives (Martinez and Martineau, 2001).

Within the developmental "appraisee centred" approach to PA, the appraisal itself is confidential and its primary function is to coach the appraisee, to encourage self-reflection and



provide help and developmental advice (Conlon, 2003), in an effort to enrich the skills of staff as well as maintain positive attitudes amongst employees to ensure and improve their performance (Boswell and Boudreau, 2002). Similarly, Wilson and Western (2000) state that appraisal can be used to coach and counsel employees, to improve communication, clarify expectations and duties and thereby improve the work environment and raise morale, again, in order to ultimately improve performance in the future. Hence, PA is often expected to aid in the process of identifying training opportunities and offer a platform for open discussion and constructive feedback. Such appraisal systems are therefore designed to find ways in which to help employees reach their own personal goals in relation to personal growth and development (DeNisi and Smith, 2014). Thus, professional autonomy remains intact or is even strengthened as there is scope for staff to participate and become empowered (Fitzgerald et al., 2003). This variant of PA strongly resonates with the 'developmental' type of PA identified by Poster and Poster (1993) which "assumes professional, collegial and collective authority to lie within the profession" and "has as its main concerns (...) the maintenance of moral, ethical and professional values" (p.9) alongside the developmental purpose.

In the hospital context, West et al. (2006) argue that PA can be useful for healthcare staff when used for clarifying expectations and discussing development needs and opportunities. Further it is suggested that when PA is guided by the purpose of nurturing staff more generally, PA can be a mechanism for ensuring staff feels appreciated, valued, encouraged and supported, thereby nurturing not only the individual but commitment within the workforce.

In a similar vein, the prescriptive literature and limited research on nurses' PA clearly advocates a more development-driven PA system (e.g. Baard and Neville, 1996; Northcott, 1997) and within the public sector more generally (Simmons, 2002; Spence and Wood, 2007). The exertion of a top-down control function associated with the judgemental approach of appraisal is widely suggested to be inappropriate in knowledge-based organisations as hospitals (Simmons and Eades, 2004, p. 155; Risher, 2005) due to the potentially negative consequences, discussed further below.

However, there are suggestions in the literature that in healthcare and hospitals a control orientation is prevalent to manage healthcare professionals, including nurses, even though a commitment-orientated approach is argued to be more appropriate, as further discussed in the 'consequences' section (Cogin et al., 2016). As such, this demonstrates that there is scope for difference in approaches to PA adopted. However, because the institutional context is effectively beyond the scope of many studies on appraisal, we know little about the different dominant purposes for nurses' PA and in how far these PA systems are informed by the wider

national context (e.g. bargaining arrangements, trade union representation, national legislation). In other words, these studies do not take into account how the context in which PA is introduced shapes PA in terms of its purpose, or whether and how PA approaches can be reshaped when implemented in practice.

#### *Soft discipline: Control & Development*

PA systems and their associated purposes may contain both elements of development and control at the same time. Yet they can be present to different degrees. Nevertheless, where the purpose of PA is concerned with both control and development, the aim is to 'control' and ensure that employees comply with the organisation and what is expected of them, whilst also adopting a development approach to ensure employees are capable and committed towards achieving the organisation's goals. This broadly fits with what Conlon (2003) suggests to be the 'performance management' type of PA which focuses on ensuring that the appraisee conforms to the organisational agenda. For employees to identify and ultimately achieve the organisational goals however, organisations might simultaneously seek to elicit organisational commitment, again, by emphasising the role of development within PA yet with elements of control via the assessment against the organisational agenda. This variant of PA has some resemblance with the 'managerial' type of PA put forward by Poster and Poster (1993) as it emphasises the achievement of targets and organisational objectives.

The traditional managerialist critique, as suggested above, whilst acknowledging complications when two seemingly conflicting purposes are pursued, still emphasises the need to gain employees' commitment and co-operation and build upon their capabilities and in fact consider PA as an important mechanism to do so (e.g. Geary, 1992). And indeed, some research seems to suggest that both control and developmental purposes are pursued at the same time.

In relation to teacher appraisal, research conducted by Fitzgerald et al. (2003) in New Zealand schools found that PA served bureaucratic, external, mandatory control purposes and attempts, yet at the same time a professional approach was adopted most importantly by incorporating the purpose of development and establishing a clear link between PA and development.

Qualitative research by McGivern and Ferlie (2007) on medical consultant PA in the British NHS shows that appraisal represents both "an assessment and a developmental exercise" (p. 1365). In other words, consultants are required to meet their targets but a developmental component still exists. However, in general it was identified that the "developmental rhetoric" is used alongside the attempt to "make professional practice more explicit, accountable and controllable" (p. 1366). Therefore, under the banner of professional development, individual

goals are aligned with organisational objectives amidst an underlying purpose of control. Responses of these consultants are discussed in the 'consequences' section further below.

Whilst these studies show that PA can be used for both control and developmental purposes simultaneously, and acknowledge the broader regulatory context in which their research is situated, little is known about the specific set of national institutional factors, such as employee voice mechanisms or national quality assurance systems, which might contribute to hospitals adopting a more control or development orientated approach or a combination of both.

#### *Soft nurturing: Judgement & Autonomy*

Another possible variant of PA is one where evaluation is the main purpose of PA with little concern for development, yet where nurses retain their professional discretion. For example, a judgement-approach to appraisal can exist regarding the measurement of targets, but this does not preclude a high degree of discretion in relation to the setting of targets or how to achieve set objectives.

Moreover, there are relevant studies that tend to indicate that despite the assessment component in appraisal, staff actually still have an input in setting their goals and discretion in how to achieve them. For example, Redman et al. (2000) in a case study of PA in a Trust Hospital in the UK, drawing on interview, survey and documentary evidence, shows that the majority of survey and interview participants indicated that within the scope of PA they are able to choose and influence their own goals and objectives against which they are assessed, both in terms of the nature and number of objectives. As such, despite appraisal entailing assessment of the individual's performance, a lot of discretion could be discerned in terms of goal-setting. However, this study does not specify who these respondents are, only that both managers and professionals from different backgrounds (excluding medical staff) were targeted.

Bolton's (2004) longitudinal, qualitative research study in the gynaecology unit of a large North West trust hospital reinforces the conclusion that although hospital managers engage in the evaluation of performance, managers recognise the need to maintain the co-operation and autonomy of nurses, as semi-professionals, a theme I discuss in the next chapter. It also indicates that the division between judgement and development is too crude to provide a nuanced understanding of the appraisal process of nurses. However, this study solely focuses on one particular unit and on nurses from one particular speciality and represents an outlier in a range of studies which either emphasise the purpose of control/evaluation or development respectively.

Overall, the studies reviewed here indicate that at closer inspection PA, specifically in the public-sector context, may pursue different kinds and combinations of purposes, as summarised in Table 2.2 below. Again, it should be noted that the approaches identified in Table 2.2 are very much ideal types and that the possibility of hybrid forms exist combining different elements of different forms of PA. Thus, to effectively investigate the impact of national institutional factors on approaches to PA, it is important to acknowledge that while PA might be either strongly concerned with discipline or conversely nurturing staff, this distinction is not necessarily clear-cut, and the purpose of discipline may be ‘softened’ via the incorporation of a purpose of development, whilst even nurturing approaches to PA might include elements of judgement, a matter which the conventional PA literature frequently ignores. This then in turn is likely to influence how PA is implemented in practice.

**Table 2.2: The ‘why’ of different approaches to appraisal**

Types of PA	Why
<b>Strong Nurturing</b> (Low control/high development)	Development + professional autonomy
<b>Strong Discipline</b> (High control/low development)	Control + judgement/ evaluation
<b>Soft Discipline</b> (High control/high development)	Control + development
<b>Soft Nurturing</b> (Low control/low development)	Judgement + discretion

Source: Author

### 2.3.2 The ‘How’: how PA is conducted

The main purpose of appraisal can be argued to be closely linked to the key features of the PA system adopted. Amongst other things, the purpose of appraisal might affect structural factors of appraisal, such as if and what kind of performance criteria is used, e.g. whether these criteria are job/results-orientated or person/ behaviour-orientated (IDS, 2011). As indicated above, the purpose of appraisal also has implications for whether PA is used for other administrative decisions and if it is linked to for example performance-related bonuses. Moreover, the ‘how’ includes the main processes involved and other characteristics of the PA process such as the extent to which scope for participation is provided for those being appraised.

#### *Strong discipline: Judgement & Control*

Where the main goal is ‘judgement’ and ‘control’, PA is a formal, reward-driven system, with potential links to individual performance-related pay or bonuses on the basis of quantifiable targets or performance criteria, as a way to discipline those who are identified to be performing poorly and seek compliance. As stated above, PA can also be related to other HR-related

decisions such as promotion, demotion, or termination. Thus, PAs can often be linked to key human resources decisions such as promotion, pay increases, and other employment practices (Cleveland et al., 1989; Shore and Strauss, 2008; Ferris et al., 2008) whereby the inherent emphasis is on judging performance.

Moreover, in such control and judgement-orientated PA systems, PA is essentially concerned with making between-person decisions and comparisons in relation to different performance criteria (e.g. Cleveland, 1989; Krausert, 2009). The assessment typically concerns past performance. This type of PA is similar if not identical to the one identified by Poster and Poster (1993; 2003) as 'judgement'. It is suggested that in this case, the focus is on collecting data "for the assessment of the subordinate" (p.9) and to rate individuals against each other. It is further stated that this PA variant uses merit-rating and relies on extrinsic motivation via the use of e.g. performance-related pay. It should be noted that there are different types or systems of variable pay as there might be e.g. individual, team or organisational bonus payments with a more short-term or long-term focus and there may also be variety in terms of the size of this component (Perkins et al., 2016). The more discipline-orientated approaches to PA are likely to focus on the individual and to be more short-term in nature.

#### *Strong nurturing: Development & Autonomy*

Appraisals primarily concerned with the personal development of individual employees are typically associated with within-person comparisons in order to identify suitable training or development opportunities (Krausert, 2009). While development-orientated PA also constitutes 'assessment', it is different in nature. In this case it relates to the employee's strengths and weaknesses to provide developmental feedback, determine developmental needs and establish development goals. Therefore, PA of this type is largely future-orientated as the focus is on the potential further development of existing strengths.

Furthermore, PA of this type may include the incorporation of coaching or mentoring as it is primarily concerned with nurturing appraisees (Boswell and Boudreau, 1999). Development-focused PA might emphasise the inclusion of personal development plans that "leave room for autonomy" (Beausaert et al., 2011, p. 532; Hemmings, 1992; Krausert, 2009). Indeed, PA of this kind envisages the active participation of the employee.

This type of PA is in line with the human relations model as suggested by Ikramullah (2013) which when applied to appraisal signifies that PA encompasses 'appraisee participation', 'employee development' and 'coaching and counselling'. This variant of PA is also similar if not equal to the 'developmental' type identified by Poster and Poster (1993). In their categorisation, they state

that within this type of PA a “bipartite approach towards enabling self-improvement is emphasised” (p.9) indicating that here PA is characterised by a two-way communication process with special attention being paid to long-term personal development.

#### *Soft discipline: Control & Development*

This type of PA can be compared to the ‘managerial’ type of PA identified by Poster and Poster (1993; 2003) and the ‘rational goal model’ as identified by Ikramullah et al. (2016). Within this approach, PA is concerned with “shorter-assessment of performance” namely in relation to set “targets in order to maximise organisational objectives” (Poster and Poster, 1993, p. 9). These goals and targets are set by management and necessary developmental support is provided alongside to support the achievement of these targets. Thus, training and development is linked to the aims and needs of the organisation and represents a mechanism for controlling performance (Myers and Kirk, 2009) coupled with a commitment to developing people.

#### *Soft nurturing: Judgement & Autonomy*

Lastly, within what is labelled here the ‘soft nurturing’ approach to PA, PA also involves the assessment and evaluation of performance (i.e. judgement) in relation to goals. However, in comparison to what is called here the ‘soft discipline’ approach, staff participate in goal-setting and retain discretion and professional autonomy. The focus is on within-person comparison in relation to personal goals set. Moreover, training and development is of little concern here and is largely individually driven.

In sum, as summarised in table 2.3, the purpose of PA can be suggested to be manifested in the way the PA system is set-up. Based on a detailed reading of the literature, it is shown in this compilation that there are many ways in which PAs key features may differ. These key features relate to the main set-up of PA including its orientation (e.g. whether it is backward or forward orientated, long-term or short-term), the extent to which developmental concerns are incorporated, the extent to which its design allows for participation, the extent to which PA is related to extrinsic (i.e. financial), intrinsic rewards or no rewards at all, and which type of comparisons are made during PA.

**Table 2.3: The ‘why’ and ‘how’ of different approaches to appraisal**

Types of PA	Why	How
<b>Strong Nurturing</b> Low control/high development	Development + professional autonomy	<b>Focus/Orientation:</b> Developmental feedback & plan; future-orientated <b>Reward:</b> Intrinsic Rewards; coaching & counselling <b>Development:</b> Long-term professional development; inclusion of development plan <b>Participation:</b> high levels of participation; authority lies within the profession <b>Comparison:</b> Within-person comparison
<b>Strong Discipline</b> High control/low development	Control + judgement/evaluation	<b>Focus/Orientation:</b> Evaluation of past performance against set criteria (rating form); short-term <b>Reward:</b> related to external rewards and punishments, e.g. merit pay; performance bonus <b>Development:</b> minimum concern with training <b>Participation:</b> little to no employee participation <b>Comparison:</b> Comparison between individuals
<b>Soft Discipline</b> High control/high development	Control + development	<b>Focus/Orientation:</b> Shorter-term assessment against pre-determined targets <b>Reward:</b> criticism and praise from superior; potential use of incentives <b>Development:</b> training and developmental support to achieve targets/tied to organisational aims and needs <b>Participation:</b> Goals and targets set by management <b>Comparison:</b> Comparison between and within individuals
<b>Soft Nurturing</b> Low control/low development	Judgement + discretion	<b>Focus/Orientation:</b> Mutual goal-setting and stocktaking; backward and forward-looking <b>Reward:</b> No extrinsic reward <b>Development:</b> development individually driven <b>Participation:</b> Participation in goal setting & how to achieve targets <b>Comparison:</b> Comparison within individual

Source: Author

When the main purpose of PA is to nurture staff via development and encourage autonomy, the PA system itself is likely to provide scope for participation concerning the issue of e.g. development. Where the main goal of PA is to control performance, the structure of PA is more concerned with setting performance standards and ensuring compliance via the evaluation of performance against these standards which might be complemented by a performance bonus element. Again, the ‘softer’ versions might display these elements to different degrees, e.g. the ‘soft nurturing’ variant might still allow for participation whilst judging performance, while the ‘soft discipline’ variant might be more directive but still incorporate a concern for individual developmental needs. Again, the traditional PA literature is largely silent on the use of these different types of PA in hospitals for nurses across different countries and whether certain national institutional settings produce the prevalence of one type over the other.

### 2.3.3 Consequences (Nurses experiences & reactions)

This section considers some of the possible consequences in relation to the different versions of PA discussed above. Some of the practical outcomes are considered, in terms of direct consequences of PA (training, monetary rewards etc.) due to the way PA has been set-up, as well as how nurses might perceive and react to distinct PA approaches. As suggested throughout this chapter, it is not known which types of PA are prevalent in different countries for hospital nurses. Little is also known about what effect each of these PA variants has on nurses or the kind of reactions PA brings about. Nursing's role and position more broadly, as a semi-profession, is discussed in the next chapter.

#### *Strong discipline: Judgement & Control*

In terms of direct outcomes, as highlighted above, 'strong discipline' or control-orientated PA variants are often associated with the use of individual performance-related pay or bonuses which means that this form of PA can, but does not necessarily, result in higher or lower payments depending on the performance evaluation results as judged by the appraiser. In more extreme cases PA can also ultimately result in promotion, demotion or termination.

As stated above, the dominant view in the academic literature is that highly control-orientated approaches are largely inappropriate specifically in the public-sector context. Professionals have traditionally been granted a high degree of autonomy and professional power (Freidson, 2001; McGivern and Ferlie, 2007) and as such control-orientated PA systems can be argued to go directly against this (Townley, 1993b). Public sector and particularly hospital workers, including nurses, are traditionally characterised as being intrinsically motivated by such things as developmental opportunities (Koff, 2017; Simmons and Eades, 2004; Northcott, 1997) which is furthermore contrary to such an approach to PA. The very nature of the work that is undertaken, which makes performance more difficult to measure than e.g. piecework, as well as the requirement of team-work and collaboration between different occupations can be suggested to make the use of control and discipline-orientated PA systems problematic (Ang et al, 2013; West et al., 2002).

Especially if PA encompasses an individual bonus element, in the context of knowledge-based occupations this is often judged as inappropriate as results are not easily measurable or controllable (e.g. Koff, 2017) and because it can have "perverse effects (...) when employees are encouraged to compete rather than cooperate" (Perkins et al., 2016, p.190). Regarding performance-related pay, research in the English NHS has shown that even though staff approves with this practice in principle, in practice however staff are "not in favour" (Corby et



al., 2003, p. 511), indicating feelings of inequity. Research tends to confirm the difficulty of establishing and implementing financial performance-related reward systems for nurses in hospitals (e.g. De Gieter et al., 2006). De Gieter et al. (2006) also report on the findings of their own thorough mixed method research, albeit in the context of Belgium, and suggest that hospital nurses tend to value psychological and non-financial rewards highly, such as appreciation or compliments from others, and often more highly than financial rewards (apart from general pay). In terms of performance-related incentives, evidence shows that such endeavours have often 'backfired' (Koff, 2017, p. 95) and rather than influencing or improving performance, in the context of nursing such methods may create conflicts alongside feelings of inequity and a general deteriorated working atmosphere (Koff, 2017; Corby et al., 2003).

Indeed, it is suggested that "resentment, resistance and alienation will occur" (Simmons and Eades, 2004, p. 155) when such control, top-down approaches to PA are adopted in knowledge-based public-sector organisations. There are different ways in which an occupation might resist certain management practices if these are perceived as a tool for discipline and control. Lauer and Rajagopalan (2002, p. 1299) differentiate between active resistance, which implies that individuals either voice their concerns and opposition or leave the organisation, and passive resistance. Passive resistance can mean that individuals a) grudgingly accept the system; b) find ways of working around the system; or c) make concerted efforts to ensure the failure of the system (sabotage). One of few studies looking at nurses PA by Northcott (1997), based on interviews with nurses at one health district within the British NHS, revealed that nurses are negatively disposed towards explicitly or implicitly control-orientated approaches to PA as this impedes their professional development and consequently alienates nurses. However, possible resistance to PA was not considered and neither was the role of national institutional factors in shaping the character of PA.

While active resistance cannot be ruled out, evidence from research concerning the public sector appears to support the notion of passive resistance. For example, Healy (1997), who looked at schoolteacher PA and concluded PA to be primarily characterised by a controlling and discipline-orientated approach, notes the effect it has more broadly expressed by the term 'appraisal disdain'. 'Appraisal disdain' implies resistance in the form of "disinterest or even contempt" (p. 216). So even though those subjected to PA might not actively resist the practice, they would not actively engage with the process and only unwillingly and minimally comply. In another study in the university context, Anderson (2008) also highlights the use of more 'subtle forms of resistance' (p. 254) or 'passive resistance', including in relation to PA, characterised by

avoiding PA processes, “subverting the managerial intention of the practice”, or through ‘minimal compliance’ (p.264-265).

The use of ratings to determine such outcomes as bonuses may not only affect general nurses and their relations with team members in negative ways, but likewise there is the issue that appraisers might not feel comfortable in their role as assessors. In fact, already McGregor (1957) highlighted that managerial resistance is likely to occur in instances where managers feel like they have to “play God” (McGregor, 1957; Grint, 1993) and “police” performance (Winstanley and Stuart-Smith, 1996). Therefore, in such circumstances managers tend to evaluate their staff leniently when those ratings are linked to any such administrative decisions (Krausert, 2009, p. 122), rendering the use of such ratings and evaluations ineffective.

Resistance could be argued to eventually shape the type of PA system in place. In a research conducted by Wilson and Nutley (2003) on Scottish universities it was found that the incidence of PA declined due to appraisers’ reluctance to participate in PA as well as “passive resistance amongst appraisees” (p. 310), reflected by a tendency to ignore PA or treating PA solely as a formality. Thus, it is possible that where this type of PA is adopted, nurses can likewise moderate the impact and influence the use of PA through their resistance. However, the ability of an occupation to influence such practices is dependent on their degree of professionalisation, an issue discussed in more detail in the next chapter.

In essence however, the more professionalised an occupation is, the more likely it is to resist such a practice and influence its practice more (McGivern and Ferlie, 2007; Boselie et al., 2002). It is often argued that nurses in Europe continue to suffer from an overall weak professional identity (Manzano-Garcia and Ayala-Calvo, 2014; Koff, 2016) which is argued to be compounded by the predominating passive attitude within nursing (Manzano-Garcia and Ayala-Calvo, 2014). Others recognise that nursing has been engaged in attempts of professionalisation (Abbott and Meerabeau, 1998) and advances within nursing have been made. Furthermore, there are reports that in fact nurses are not necessarily ‘passive’. More broadly, Traynor (1999) reports that on the whole nurses tend to take a shared view and respond to ‘threats’ stemming from managerialism in similar ways. In response to managerialism within healthcare it has been reported that nurses “believe they are resilient, that they are resisting the opposing forces” (Cope et al., 2015, p.120). As such, nurses might view and respond to PA in similar ways and still exert efforts to influence e.g. the way PA is practiced. However, many of these studies have been conducted in the UK where ‘new public management’ reforms have had a deep impact and there is a lack of studies examining the responses of nurses to specific forms of PA in different contexts.

Given the somewhat ambiguous status of nursing as a semi or 'quasi-profession', it is important to take a closer look at nursing's position in the next chapter to be able to formulate expectations about the extent to which nursing as a profession has the potential to influence PA practices or challenge certain PA practices.

#### *Strong nurturing: Development & Autonomy*

From a practical standpoint, development-orientated appraisal can result in various further developmental activities, such as formal off-the-job training and education as well as on-the-job training. Through the acquisition of new skills, PA can in effect result in the expansion of the current role or even promotions. Thus, PA can be used to prepare staff for possible future roles and can thus have indirect links to staffing decisions (Krausert, 2009). However, PA of this type is generally unrelated to remuneration or other tangible rewards and is not directly connected to administrative decisions.

As indicated above, this type of PA is regarded as an approach more appropriate for professionals, at least according to the conventional PA literature. Developmental PA is likely to appeal to those intrinsically motivated (Daley, 1992) as typical for public sector workers, as training opportunities might be valued by staff and regarded as non-financial rewards (Krausert, 2009). When the focus is on development, encouragement and coaching within the PA process, PA as a whole is likely regarded as enabling and therefore, positive attitudes can be expected regarding this approach to PA alongside generally positive reactions (Kim and Holzer, 2016; Boswell and Boudreau, 2000). Development-focused, participative PA is also associated with greater acceptance rather than resistance to PA (Kim and Holzer, 2016). Specifically, in the hospital context, development-orientated PA is argued to contribute to positive feelings such as feelings of appreciation and being valued as well as greater commitment (West et al., 2006).

Again, Northcott's (1997) qualitative study of British nurses indicated that nurses themselves would welcome PA of this type and appreciate the provision of developmental feedback. Nurses suggested that this type of PA would, if adopted, likely contribute toward their own "professional fulfilment" as well as "satisfaction, reassurance and personal reward" (p. 140) and motivate them to pursue continuing or further professional development which is predicted would improve performance overall. In addition, as a consequence of a more professional, nurturing type of PA, nurses envisaged that this would lead them to "explore new areas of work" (p.140) which could encompass the expansion of their current role. However, these consequences were hypothetical rather than actual experiences.

Overall, there are not many accounts of the effects of more nurturing types of PA on nurses. This may reflect control-orientated features dominating in contexts where NPM has the most impact. It is not clear whether and/or which institutional factors might promote a more development-orientated variant of PA in the hospital context. It is also unclear whether general hospital pressures across countries, further discussed in the subsequent chapter, are overriding any differences stemming from the national institutional context to produce more control-orientated approaches or, alternatively whether there are distinct prevalent approaches to PA in different countries. These are the questions this thesis seeks to address and are further discussed in the following chapters. The possibility of hybrid forms of PA is also considered.

### *Soft discipline: Control & Development*

As suggested above, where a combination exists and PA systems constitute both purposes of control and development, the consequences of PA appear more mixed. In terms of direct practical outcomes, training might still be agreed as part of PA alongside the monitoring of target achievement or non-achievement which may or may not be linked to monetary rewards, depending on how 'strong' the control element is.

A significant proportion of the PA literature would suggest that when PA is used for apparently conflicting purposes, i.e. both control and development, then PA is likely to be less effective due to the inherent tensions between these purposes (Boswell and Boudreau, 2002; Zedeck and Cascio, 1982; Murphy and Cleveland, 1995; Wilson and Western, 2000). It is suggested that those involved in the appraisal may be uncomfortable to speak openly about developmental needs in a context where performance is being judged/assessed and the emphasis is on discipline and compliance (e.g. Wilson and Western, 2000). However, the consequences of a PA system are also likely to depend on the relative emphasis placed on the different elements.

In relation to consultant PA, as reported above, McGivern and Ferlie (2007) identify it to be both "an assessment and a developmental exercise" (p. 1365) but also considered the assessment component and control purposes to be the dominant aspect. The consequence for consultants was that whilst some perceived the PA process as developmental and others as control, the majority treated PA as a mock ritual and a tick-box exercise. It could be argued that by "'gaming' around targets (...) or superficially 'absorbing' it at local level" (p. 1364) consultants at least passively resisted PA and were able to limit the effect of PA. However, it is not clear to what extent nurses, as a semi-profession, might do the same.

In relation to the study mentioned earlier by Fitzgerald et al. (2003), likewise, both control and developmental purposes could be identified for teacher appraisal in New Zealand. In comparison

to the case of consultants in the British NHS (McGivern and Ferlie, 2007), overall, a “professional response” to PA was found to dominate. Teachers agreed that they should be accountable, valued the PA process and, in general, perceived it as a reflective practice. The key contributing factor for these positive perceptions is attributed to the fact that teachers were involved in the “development *and* implementation of appraisal policies and processes” (p.96).

This brings us back to the role of the national institutional context which may play an important role. For example, national legislations, differential roles of trade unions, WCs and more broadly distinct industrial relations systems may influence the extent to which key stakeholders are involved in the establishment of the practice and how they view and receive it. These and other potential institutional factors are discussed in the next chapter as well as the nursing occupation and its potential to influence PA through e.g. professional associations.

#### *Soft nurturing: Judgement & Autonomy*

Finally, the ‘soft nurturing’ variant of PA which constitutes elements of judgement and discretion has the least direct concrete consequences. It can result in further development activities but this is essentially individually driven. Despite the assessment component, this is typically not related to any administrative decisions. In terms of wider-reaching consequences, evidence appears more mixed.

As highlighted previously, a key difference between this type of PA and the ‘soft control’ type is that goals or objectives are not set by management but are mutually agreed. Northcott’s (1997) interviews with nurses indicated that this is likely a more beneficial approach for those involved. Indeed, nurses speculated that if they would be able to participate in goal-setting, the achievement of these goals would then provide them with a sense of satisfaction and fulfilment.

Certainly, the chances of resistance are less likely in ‘strong’ as well as ‘soft’ nurturing-orientated approaches to PA. Bolton’s (2004) case study in relation to new public management practices more generally, including PA, showed that managers recognised the need to maintain cooperative relations and not to interfere with nurses’ traditional autonomy. This, according to Bolton (2004, p. 330) largely prevented resistance to arise.

As stated earlier, in Redman et al.’s (2000) case study of a hospital trust in the UK, PA exhibited elements of judgement alongside scope for appraisees to set their own goals and objectives. While it is suggested that overall both managers and professional staff found the PA experience valuable, conversely, it was also found that in many cases PA represented a process where those involved simply go “through the motions (...) to get it over with as quickly as possible” (p. 57) – in other words, PA yet again became a tick-box exercise.

Given that many studies on PA tend to focus on certain aspects of the PA process respectively rather than holistically (Ikramullah et al., 2016), e.g. either focusing on PA perceptions or PA purposes, it is not possible to ascertain which consequences follow this PA type, however it is likely that where PA purposes are blended in some way, reactions to PA will be more measured and the precise PA perceptions will vary depending on the emphasis placed on the different elements of the PA type.

**Table 2.4: The ‘why’, ‘how’ and consequences of different approaches to appraisal**

<b>Types of PA</b>	<b>Why</b>	<b>How</b>	<b>Consequences</b>
<b>Strong Nurturing</b> Low control/high development	Development + professional autonomy	<b>Focus/Orientation:</b> Developmental feedback & plan; future-orientated <b>Reward:</b> Intrinsic Rewards; coaching & counselling <b>Development:</b> Long-term professional development; inclusion of development plan <b>Participation:</b> high levels of participation; authority lies within the profession <b>Comparison:</b> Within-person comparison	Training & development, enhanced skills, acceptance & satisfaction with PA
<b>Strong Discipline</b> High control/low development	Control + judgement/evaluation	<b>Focus/Orientation:</b> Evaluation of past performance against set criteria (rating form); short-term <b>Reward:</b> related to external rewards and punishments, e.g. merit pay; performance bonus <b>Development:</b> minimum concern with training <b>Participation:</b> little to no employee participation <b>Comparison:</b> Comparison between individuals	Feelings of control; performance pressure; Resistance (active/passive)
<b>Soft Discipline</b> High control/high development	Control + development	<b>Focus/Orientation:</b> Shorter-term assessment against pre-determined targets <b>Reward:</b> criticism and praise from superior; potential use of incentives <b>Development:</b> training and developmental support to achieve targets/ tied to organisational aims and needs <b>Participation:</b> Goals and targets set by management <b>Comparison:</b> Comparison between and within individuals	Tick-box exercise; developmental aspect valued
<b>Soft Nurturing</b> Low control/low development	Judgement + discretion	<b>Focus/Orientation:</b> Mutual goal-setting and stocktaking; backward and forward-looking <b>Reward:</b> No extrinsic reward <b>Development:</b> development individually driven <b>Participation:</b> Participation in goal setting & how to achieve targets <b>Comparison:</b> Comparison within individual	Motivation to achieve goals or Tick-box exercise

Source: Author

As Table 2.4 summarises, different types of PA constituting different purposes and key features are suggested to lead to distinct consequences in practice, as also reflective of the literature

reviewed in this chapter. This has the implicit assumption that these three dimensions, i.e. the why, how and consequences of PA, are connected and that staff would make accurate attributions of the “why” of PA. In fact, the way in which HRM practices like PA are received by the workforce, and thus affects their attitudes and behaviours, is likely to depend on the attributions of the “why” employees make, i.e. why it is thought management adopts certain practices (Nishii et al., 2006). For example, nurses may make external attributions (management has to adopt the practice due to external reasons) or different internal attributions (management wants to adopt PA e.g. to control employees versus to gain their commitment), which may or may not match with the intended reasons of PA. Therefore, this thesis does not ignore a potential disconnect between these dimensions of PA.

## 2.4 Conclusion

This chapter began by outlining how the meaning of PA has evolved. Subsequently, this chapter provided a brief overview of the wider PA literature. It was highlighted that research on PA tends to focus heavily on micro-individual or process issues to the exclusion of distal factors that may shape the character and consequences of PA. This has led to a significant lack of understanding in terms of how distinct national contexts produce potentially different approaches to PA.

Based on relevant PA literature and important dimensions it raises, this chapter developed a typology which differentiates between four PA approaches which differ in terms of the ‘why’, ‘how’ and consequences, whilst acknowledging the possibility of hybrid forms of PA. At the one extreme end, the nature of PA can be largely judgemental and associated with attempts to ‘control’ (*Strong discipline*). Reactions to this type of PA may range from dissatisfaction to passive or even active resistance. At the other end of the scale, PA can be predominantly developmental in nature. This approach is largely seen as helpful to professionals and does not stand in conflict with autonomy (*Strong nurturing*). Indeed, such a type of PA could in fact have positive connotations for nurses in relation to their own professional development, commitment and motivation.

However, PA is often used for different and at times conflicting purposes. A judgemental approach to PA may exist with an assessment against targets yet in a context of considerable degree of professional autonomy (*Soft nurturing*). As many organisations ultimately seek to foster a committed workforce which is motivated to achieve organisational goals, PA may be used to elicit organisational commitment through a more developmental approach yet with elements of control via the assessment against the organisational agenda (*Soft discipline*). When PA is used for mixed purposes, a range of outcomes could be expected depending on the relative

emphasis of these distinct purposes. Nonetheless, it is likely that under these circumstances PA is primarily treated as a tick-box exercise rather than representing a wholly fulfilling or threatening experience.

Although PA is generally increasing within healthcare, which indicates a similar trend across countries, it is not clear if PA is being used developmentally or judgementally or in some blended way. This implies scope for cross-country difference. However, the institutional context is effectively beyond the scope of much of the conventional research on PA. Few if any of these studies consider the role of e.g. trade unions, works councils, differing regulatory contexts or varying demands from accrediting bodies. Since no study could be found which takes a comparative perspective regarding hospital nurses' PA, we know nothing about the way in which hospitals across countries diverge or converge in terms of their PA practices. This thesis seeks to redirect and contribute to existing research by examining the influence of national institutions on PA. Having identified and critiqued the absence of a wider perspective of PA that goes beyond the micro-individual lens in this chapter, the next chapter builds on this discussion by delving into debates around convergence versus divergence and the role of national institutions.



## Chapter 3: The convergence-divergence debate and institutional perspective

### 3. Introduction

The preceding chapter established that although the performance appraisal (PA) literature indicates that there are potentially different types of PA, the role of national institutions in shaping PA approaches is largely neglected. This is accompanied by a lack of comparative research, particularly in the public sector. This thesis seeks to address this gap by examining if shared pressures lead to similar PA approaches or if national institutions lead to differences in PA practices and to what effect. This chapter considers two main scenarios manifested in the debates around convergence versus divergence and formulates concrete propositions on this basis in order to answer the related research questions more effectively. As Yin (2003, p. 11) argues, the use of propositions “helps to focus attention on certain data and to ignore other data” and are thus useful in guiding this research.

Section 3.1 presents the convergence and universalist perspective. In line with this perspective it is argued that due to similar cross-national pressures, hospitals across countries will develop an increased shared emphasis on PA. A range of shared pressures for efficiency and quality on hospitals are discussed and how this may lead to an increased use and similar types of PA across countries. The importance of distinguishing between different levels of convergence, reflected in the different dimensions of PA, is also considered. Special attention is also paid to the nursing profession and its potential to contribute toward convergence.

Section 3.2 explores the divergence perspective, exemplified by institutional theory. According to this perspective, cross-national pressures are moderated by the national institutional environment within which hospitals are deeply embedded, leading to variation in PA practice in hospitals across countries. Key concepts within institutionalism are briefly highlighted before clarifying the model focused on in this thesis to guide the identification of relevant institutional factors. Subsequently, the potential role of the following institutional factors are discussed: the broader healthcare system, including national quality assurance systems, as well as the industrial relations system, including collective bargaining arrangements and the role of trade unions and works councils (WCs). The potential issue of within-country variation is also acknowledged.

### 3.1. Universalist view: convergence across and within countries

Debates regarding the international convergence versus divergence of organisational practices are both long-standing (e.g. Maurice et al. 1986; Crouch and Streeck, 1997) and ongoing as it continues to be an important relevant research area across disciplines (e.g. Al Ariss and Sidani, 2016; Dalton and Bingham, 2016; Brewster, Mayrhofer and Cooke, 2015; Brewster, Sparrow and Vernon, 2010; Mayrhofer et al., 2011; Poor et al., 2011; Streeck, 2009). More recently this debate has gained attention within the HRM literature as well (Tregaskis and Brewster, 2006; Brewster et al., 2007; Budhwar et al., 2016). The convergence-divergence debate essentially raises the question if organisations and their practices are becoming increasingly similar across different countries. While the convergence perspective suggests that organisations and their (HR) practices are becoming more alike across countries, the divergence perspective posits the opposite, namely that organisations and their HR practices diverge from each other in significant ways or, at least, continue to exhibit similar degrees of difference (i.e. non-convergence).

According to Gooderham, Nordhaug and Ringdal (1999) the notion of convergence can be suggested to be underpinned by the so-called rational perspective which adopts the broad view that “uniform pressures will lead to uniform (...) organizational practices” (p. 507). This means that when faced with similar challenges in the organisational environment, the rational view is that organisations will seek similar solutions to these problems (Mayrhofer et al., 2004). This rational model assumes that organisational practices are universal regardless of the country in question, at least when considering the same industry (e.g. Hall and Goodale, 1986; Dessler, 1997).

The convergence perspective is furthermore in line with the universalist paradigm which argues that there is a universal set of best practices (e.g. Pfeffer, 1994; 1998) and specific HR practices, which are generally superior and, when adopted, will bring benefits to organisations in the form of higher organisational performance regardless of the organisation’s wider institutional context or environment (e.g. Dewettinck and Remue, 2011; Kaufman, 2016; Pudelko and Harzing, 2007; Pudelko, 2006; Brewster, 2006). The convergence and universalist perspective is thus underpinned by the ‘logic of effectiveness’ [see more in Martín-Alcázar et al., 2005; Pollitt, 2001a] which postulates that given the efficiency gains that the adoption of these universally best practices brings, organisations are compelled to adopt these practices to remain competitive. Empirical evidence in many cases appears to confirm the assertion that there are certain HRM principles which are universally ‘true’ and most appropriate across the board. For example, in relation to the so-called ‘high performance work practices’, evidence seems to suggest that a certain set of best HR practices have routinely been shown to lead to improved

outcomes for the organisation regardless of national context (Paauwe et al., 2013). Again, this perspective therefore assumes that organisations across countries will 'converge', leading to growing similarities in organisational and managerial practice.

Supporters of the convergence thesis emphasise that worldwide developments in relation to technological innovation, globalisation and general competitive pressures will contribute towards more and more similarity in organisational practices, including HRM practices and PA, eventually leading towards convergence (Kerr et al., 1960; Giddens, 1990; Kerr, 1983; Kidger, 1991; Huo et al., 2002; Tayfur 2013). A central argument is also that country-specific institutions, specifically those related to industrial relations systems, are eroding, thereby further contributing toward convergence because the ability of such institutions to 'filter' HRM practices is affected. A weakening of such institutions has been ascribed even to countries which have been typically characterised by 'strong' institutions (see e.g. Hassel, 1999; Addison, 2006, 2014; Bispinck et al., 2010; Benassi, 2016). Thus, due to the institutional erosion, the scope for the adoption of similar organisational practices across countries is increased, particularly as organisations are confronted with similar pressures. The overall argument is that these cross-national pressures create incentives for organisations worldwide to adopt leading HR practices, usually originating from the US, and as a consequence it is expected that organisational practices would eventually converge towards this 'US model' (Kidger, 1991; Dewettinck and Remue, 2010; Kaufmann, 2016).

However, Mayrhofer and Brewster (2005) identify two variations of the convergence argument. The first is the market-led argument, i.e. the traditional convergence perspective described above, which suggests that a worldwide trend of convergence of organisational practices exists. The second version is more critical about the applicability of US-orientated practices across the globe. Instead, it suggests that convergence regarding HRM practices can be broadly identified to be occurring within certain broad regions such as within the US and within Europe respectively due to, for example, the regulatory influence of the European Union. Indeed, Mayrhofer and Brewster (2005) identify that European countries overall differ in terms of HRM practices in comparison to the US. Therefore, this thesis focuses on countries within the EU to account for the assertion of a 'European model' (e.g. Mayrhofer and Brewster 2005; Scholz and Müller, 2010; Vanhala et al., 2006).

Since this study focuses on public sector hospitals, it is worth highlighting that also within the public management literature convergence arguments exist (Goldfinch and Wallis, 2010) and the universalist view can be found. Influential authors have argued that the movement towards so-called New Public Management (NPM) practices as a response to wider pressures is inevitably

global and signifies a worldwide trend of convergence (e.g. Osborne and Gaebler, 1992). The concept of NPM itself of course encompasses a variety of practices and changes, such as in relation to organisational structures (Hood 1995), however there is a general recognition that NPM also implies a greater emphasis on performance management (PM) in the public sector. Indeed, it can be identified that across the developed world, a widespread management trend in the public sector has been to introduce an emphasis on measurable results in an effort to achieve and demonstrate 'value for money' (OECD, 2005; OECD, 2011). Like NPM more broadly, the rise of PM has been argued to reflect an international trend (Hood, 2012) which in the hospital sector can be suggested to be reflected amongst other things in the spread of performance indicators (e.g. Pollitt, 2007). In fact, it has been suggested that in the aftermath of the most recent economic recession, PM will likely be an increasingly important theme in public management (OECD, 2010; Mercer, 2011; Pollitt, 2013).

As established in chapter 2, PA is an important element of PM and can thus be regarded as one component of NPM (e.g. Dahlstrom and Lapuente, 2009, McGivern and Ferlie, 2007; Chamberlain, 2010). When it is argued that management practices in the public sector are becoming increasingly similar due to various common performance pressures, and that managerial strategies are being copied (Kettl, 2000), at least across the developed world (OECD, 1995), this argument can be extended to HRM practices including PA. Hence, based on this stream of literature, it can be suggested that due to shared cross-national pressures, public hospitals are compelled to adopt similar policy initiatives in response to these pressures which would in turn imply a shared increased emphasis on individual performance and use of PA.

The following section discusses wider pressures and discernible common trends in the hospital sector throughout Europe in more detail such as pressures stemming from demographic changes, demands for quality and efficiency, privatisation and fiscal constraints. Subsequently, different levels of convergence will be briefly considered to highlight the importance of examining the different dimensions of PA (i.e. the 'why', 'how' and 'what'), as set out in chapter 2, and to discuss in what ways these cross-national pressures may precisely affect PA.

### 3.1.1 Cross-national pressures for performance

It has been suggested that "enhancing public sector performance has taken on a new urgency in OECD member countries as governments face mounting demands on public expenditure, calls for higher quality services and, in some countries, a public increasingly unwilling to pay higher taxes" (OECD, 2005, p. 56). As a response, various OECD countries have begun to implement a range of approaches to management in the pursuit of enhancing efficiency and performance

(Lindlbauer et al., 2016). Particularly in the hospital sector there is considerable interest to improve performance, increase efficiency and reduce costs due to the high proportion of health expenditure it accounts for (Lindlbauer et al., 2016; Rotar et al., 2016; Jeurissen et al., 2016), whilst maintaining quality, reflected in recent healthcare reforms across the EU (Giovannella and Stegmüller, 2014; Clemens et al., 2014; Angelis et al., 2017). This sub-section considers the various factors which create these mounting performance pressures at the organisational level in more detail in the context of Europe and which potentially contribute toward PA convergence.

Galetto et al. (2012) effectively summarise the various external pressures hospitals face across the EU, which will be reviewed in the following paragraphs in more detail. These pressures concern, firstly, demographic changes associated with an ageing population. Secondly, technological developments and demands for new medical technologies and treatments put further pressures on hospitals. Thirdly, budgetary and financial constraints, are becoming, according to Galetto et al. (2012), even tighter. These constraints can in turn be associated with a trend of hospital privatisation as well as common changes to hospital payment systems across the EU, namely the introduction of 'Diagnosis-related group' (DRG). Lastly, growing concerns for the quality of care across Europe increases pressures for hospitals.

Firstly, pressures stemming from demographic trends should not be underestimated as these are frequently highlighted in current debates around healthcare in advanced economies. Indeed, one of the greatest challenges facing healthcare across Europe and the developed world is the overall ageing population (Rechel et al., 2009; Alexa et al., 2015; Glassner et al., 2015), exacerbated by a context further characterised by fiscal challenges and associated needs for greater efficiency. In turn, the ageing population puts major strains on healthcare finances (Rachel et al., 2009; Oliver et al., 2014) and age-related public spending is predicted to increase in the EU (Rechel et al., 2009). At the same time, the demographic shift, which has occurred due to declining birth rates and increasing life expectancy, means that there is an increase in the use of health services (Rechel et al. 2009) and patients now have, and will continue to have, more complex, multiple and often chronic health problems, which many health services are currently not equipped to deal with efficiently (Oliver et al., 2014; Dustmann et al., 2015). The ageing population also means that the healthcare workforce itself is ageing which will contribute to a growing lack of human resources in the future (Hardy et al., 2012; Alexa et al., 2015; Dustmann et al., 2015; Sherman et al., 2013). The global labour shortages in the health sector has already reached crisis point (Aluttis et al., 2014) and is accompanied with a misdistribution of skills (Kuhlmann et al., 2013). Amongst other occupational groups, the nursing workforce is particularly affected and a nursing shortage of 600,000 nurses (Filkins, 2011; Sherman et al.,

2013) as well as a shortage of one to two million healthcare professionals overall has been projected by 2020 in Europe alone (Kuhlmann et al., 2013). Furthermore, cost pressures stemming from technological developments are significant. In fact, the spread and growing complexity in relation to technology for diagnoses and treatment of patients is suggested to have an even larger impact on healthcare costs than ageing (Rechel et al., 2013; Rechel et al., 2009; Jacobzone, 2001).

Further pressures on hospitals stem from privatisation and marketisation trends in many countries, resulting from policies and efforts to increase efficiency and optimise service delivery, in both Western Europe and Central and Eastern Europe (e.g. Albrecht, 2009; Hardy et al., 2012; Klenk and Reiter, 2016). Moreover, in many European countries an overall reduction in the number of hospitals has taken place (e.g. Papouschek and Böhlke, 2008). In fact, attempts to improve efficiency is suggested to be one of the “convergent characteristic” (Albrecht, 2009, p. 449) and privatisation remains one important mechanism through which this is being endeavoured. In Germany for example, this privatisation trend has been particularly pronounced (Glassner et al., 2015; Greer et al., 2013), although still, Germany is solely regarded as a specific manifestation of a ‘mega-trend’ of hospital policy in Europe (Mosebach, 2009; Klenk and Reiter, 2016). As privatisation implies a threat to the traditional ‘labour relations regime’, employment and working conditions as well as an increased emphasis on performance criteria, trade unions in Europe attempt to respond with various defensive and more active strategies in the public sector (Schulten et al., 2008).

Another general trend which can be identified in the EU is the introduction or implementation of so-called ‘Diagnosis-related group’, i.e. DRGs, or DRG-based hospital payment systems in relation to hospital financing in one form or another (Busse et al., 2011). Despite some national variations, it is noted that it is striking that a broader path convergence can be identified in relation to payment models utilised in hospitals across Europe and across OECD countries, with DRG-based hospital payment systems being the principle mechanism (Langenbrunner, 2011; Scheller-Kreinsen et al., 2011, Tan et al., 2014; Jeurissen et al., 2016). According to Scheller-Kreinsen et al. (2011), with DRG-based hospital payment systems patients are categorised into certain DRGs, each of which “is associated with a specific cost weight or tariff, which is usually calculated from information about average treatment costs of patients falling within a specific DRG (...)” (p. 1166). Whichever specific variant of DRG is employed, hospitals are thereby effectively “exposed to the financial risk of having costs above the payment rate and are rewarded for keeping costs below” (Schneller-Kreinsen et al., 2011, p. 1166). Hence this puts pressures on hospitals. Via this incentivisation of improved performance, the adoption of DRGs

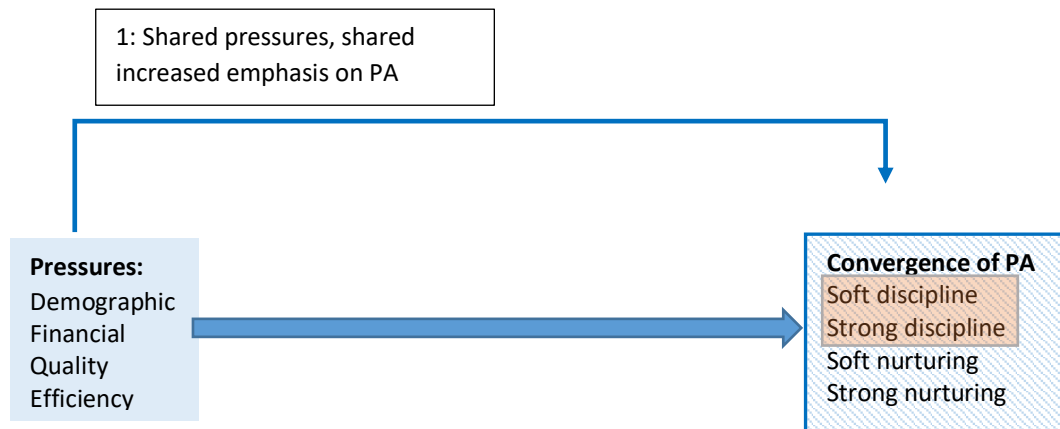
typically implies reduced length of hospital stay for patients and a reduction in services per patients, alongside an overall increase in the number of cases (i.e. patients) (Geissler et al., 2011; Busse et al., 2013; Busse et al., 2011). One more recent trend within the development of DRG systems across Europe is the incorporation of incentives for improving quality as well, given concerns that quality may be negatively affected (Schneller-Kreinsen et al., 2011).

Thus, alongside “unrelenting fiscal pressure” (Jeurissen et al., 2016, p. 16) in the hospital sector as well as pressures arising from an ageing population such as increased demand (Cope et al., 2015), there is considerable public and political interest and concern of hospitals performing effectively not just in terms of efficiency but also in terms of quality of care (McKee and Healy, 2002; OECD, 2010; Lindlbauer et al., 2016; Rotar et al., 2016). Baluch et al. (2013) call this the hospitals’ “dual challenge of improving quality and reducing costs” (p.3038). Indeed, according to Groene et al. (2010, p.2): “quality and safety problems persist and the debate on how to accelerate and sustain quality improvement is more relevant than ever” across Europe. The concern for quality is further reflected by the increase in importance of ‘quality management’ and associated themes as well as the rise of external hospital quality assurance across nations. Via standardisation processes involved in external quality assurance, quality is sought to be maintained whilst increasing efficiency. External quality assurance, including certification and particularly accreditation, is increasing worldwide (Somrova and Bartlova, 2012; Lindlbauer et al., 2016) which is also evident in the growth of healthcare accreditation programmes since the 1990s in Europe (Shaw et al, 2010b).

In sum, the public and hospital sector face a range of common pressures for organisational performance, in terms of efficiency but also in terms of quality (e.g. Rotar et al., 2016) throughout Europe. These pressures are associated with e.g. demographic changes, drives for privatisation and fiscal constraints alongside demands for quality and accountability. Many of these trends such as privatisation and the introduction of DRGs have been associated with NPM and related efforts to increase accountability (e.g. Simonet, 2004; Van Essen and Pennings, 2007), efficiency or transparency as well as quality assurance (Busse et al., 2013). This has resulted and is exemplified by the increased emphasis on PM on the one hand and quality management on the other. As an important dimension of PM, it could therefore be argued that the practice of PA has increased as these shared, cross-national pressures on healthcare systems lead to an increased emphasis on performance and in turn on PA in hospitals across countries. This possibility is depicted as proposition 1 in Figure 3.1. Figure 3.1 shows that various shared pressures, on their own, lead to convergence (i.e. similarity) in terms of an increased emphasis on PA.

**Proposition 1:** *Shared, cross-national pressures on healthcare systems lead to an increased shared emphasis on PA.*

**Figure 3.1: Proposition 1 – Convergence (between and within countries)**



The next sub-section briefly considers in what ways this shared emphasis on PA could influence the character and consequences of PA. This aspect is highlighted by the orange sub-box within the ‘Convergence of PA’ box in figure 3.1 and indicates that due to the pressures identified above, convergence may be expected toward more discipline-orientated types of PA, as discussed in the following section. It thereby emphasises the importance of not only considering the spread of PA across countries but also the different dimensions of PA (in relation to the why, how and consequences of PA) to be able to fully answer the research question if common pressures lead to similarity or whether and how the national institutional context produces different approaches to PA and at what level.

### *Convergence levels*

So far it has been argued, in line with the convergence and universalist perspective, that given the similar pressures hospitals are confronted with across countries, especially in Europe, public policy initiatives focused on increasing performance are introduced which leads to an increased emphasis on and use of PA. In addition to that, it may be expected that PA practices themselves are becoming increasingly similar across different countries, meaning that PA systems are likely to exhibit similarities in relation to the dimensions of PA introduced in chapter 2, namely the purpose of PA (why), the key features of PA (how) as well as the consequences of PA in practice.

These dimensions are reflective of different levels of convergence. Several writers have highlighted the importance of taking different levels of convergence into account when assessing the extent of similarity or degree of convergence as it is suggested that even if there are similar trends in terms of HR practices, e.g. within European countries, substantial



differences can remain, thus not reaching fully-fledged convergence (Mayrhofer et al., 2011; Pudielko, 2006; Mayrhofer and Brewster 2005, p.2). Pollitt (2001a) identifies four levels of convergence and differentiates between discursive convergence (i.e. more and more 'talk' about a particular idea), decisional convergence (i.e. decision to adopt practice), practice convergence (i.e. actual implementation of practice), and results convergence (i.e. outcomes of practice). Again, these different levels of convergence are reflected in the different dimensions of PA under investigation here. More specifically, 'decisional convergence' is covered by the investigation of the reason for introducing PA [why], 'practice convergence' relates to the 'how' of PA (i.e. how does PA look like in practice, how is it executed) and 'results convergence' is congruent with the 'consequences of PA'. Pollitt (2001a) detects that only the first two levels, i.e. discursive and decisional convergence, tend to be the subject of research which might lead to the impression of convergence, despite a lack of actual 'full' convergence in all its facets. In a similar vein, Brewster et al. (2007, p. 68-69) differentiate between, 'directional convergence' which implies that a certain trend is in the same direction, meaning for example that a practice is increasingly adopted, and secondly, 'final convergence', meaning that the trend is not only similar but toward a common end point, meaning that it has similar outcomes, thus highlighting the importance of investigating the particular trend or practice in more depth. This thesis addresses this issue by investigating not only the extent to which PA has been adopted in different countries but also by exploring the actual practice level, e.g. how PA is implemented in action, as well as the actual outcomes of this practice.

As the universalist perspective would suggest, similar organisational pressures, particularly in relation to the increased emphasis on organisational performance exemplified by the reported spread of PM, coupled with the similar organisational context, have the potential to not only lead to the convergence of HRM practices, including PA, in terms of their take-up but also in terms of the character and consequences of these practices. As highlighted in the preceding chapter, PA in the public-sector context, including in hospitals, is often introduced as a managerial tool not just in an effort to increase performance and efficiency but also to demonstrate accountability particularly in relation to professional staff even those who have traditionally been granted a lot of autonomy (McGivern and Ferlie, 2007; Azzone and Palermo, 2011; Butterfield et al., 2004; Pinheiro et al., 2016). More generally, there are indications that particularly hospitals tend to adopt more control-orientated HRM practices for healthcare staff (Cogin et al., 2016; Aiken et al., 2013). Evidence from the British healthcare sector tends to confirm this assertion and uses of PA systems with dominant elements of judgement or even control with the underlying assumption that this makes professionals more accountable (e.g.

McGivern and Ferlie, 2007). More broadly, Brunetto and Farr-Wharton (2004) also find that the implementation of public management reforms in Australia has implied the introduction of policies which seek to increase accountability, which in turn has negatively affected nurses' experiences of autonomy and job satisfaction.

Although evidence in relation to the uses of PA in the public sector tend to concentrate on Anglophone countries, in accordance with the traditional convergence perspective, it would be reasonable to assume that due to similar performance, quality and accountability pressures, hospitals throughout different countries are likely to adopt PA practices which are orientated more towards discipline and compliance (as indicated by the orange sub-box in Figure 3.1) in relation to set performance indicators or criteria, with an emphasis on results as characteristic of public management reform more broadly (Hood, 1997). However, whether this is indeed the case and the extent to which PA is orientated towards discipline, e.g. 'strong' or 'soft' discipline as illustrated in the framework for comparison introduced in chapter 2, is uncertain and an empirical question to be explored in this study.

In sum, after having reviewed the convergence perspective as well as the shared, cross-national pressures on healthcare systems across Europe, which are argued to lead to an increase in emphasis and use of PA, consideration was given to the importance of investigating not just the adoption stage of PA but also the implementation and results stage. Furthermore, if the wider pressures are 'powerful' enough, they can be suggested to override any potential differences stemming from the national institutional context to produce convergence in the type of PA. Due to the nature of these wider performance pressures, it could be tentatively argued that the character of PA is converging toward more discipline-orientated forms of PA.

The next section briefly looks at the nursing literature, the occupation of interest in this thesis and its potential to contribute toward PA convergence. In looking at the literature on the nursing profession, it will be argued that a high level of professionalisation amongst nurses on the basis of shared values and principles, leads to similar approaches to PA in different countries.

### 3.1.2 Nursing Profession

This section identifies that much of the nursing literature implies that nursing takes a special position because it shares many generic features across countries, at least within Europe. It begins by highlighting some of these shared features such as in terms of regulation, nursing's common historical background and its broad categorisation as a semi-profession. Then, the concepts of the 'full profession' and 'professionalisation' will be briefly explored to effectively define the term 'semi-profession'. This classification of nursing is important because it has previously been argued that HRM practices and their impact can be shaped by the profession in question, depending on the relative degree of professionalisation (Boselie et al., 2002). Thus, the key issue is nursing's level of professionalisation and its ability to shape PA. Given the focus on nurses in this thesis and nursing's somewhat ambiguous status of a semi or 'quasi-profession', it is important to take a closer look at nursing's position more broadly and to examine the extent to which nursing has the potential to directly influence PA, thereby contributing to convergence of PA.

#### *Nursing as a semi-profession*

Across Europe, the healthcare sector represents one of the traditional service sectors, within which the nursing profession is a core occupation (Kirpal, 2003; OECD, 2012). Nursing plays a significant role in health systems across Europe and is the single largest occupation in most countries (Bureau, 2013; OECD, 2012; Koff, 2016), and indeed the largest labour force within the EU (Keighley, 2016). Undoubtedly, nurses across Europe and beyond play a crucial role in patient care in the healthcare sector and in hospitals. Nurses are the occupational group which has the closest interaction with patients and therefore the patient experience depends largely on nurses (Stone et al., 2011).

An important historical aspect of nursing in Europe is that it has traditionally been a gendered occupation which has its roots in a religious ethos of service. These two factors have hindered an early progression of nursing as a profession (Camano-Puig, 2005; Manzano-Garcia and Ayala-Calvo, 2014). Nursing can be regarded as both, a traditional and a young profession at the same time - traditional in the sense that it has always existed in some shape or form, but young since only after the 19<sup>th</sup> century specific training for the nursing profession has been established (Manzano-Garcia and Ayala-Calvo, 2014). Since then, it has been argued that nursing has flourished and broadly speaking has shifted from being a task-orientated occupation towards being a scientifically orientated one, i.e. more like a profession with a body of knowledge and not just allocated tasks. This has led to a dynamic debate about the professional status of nursing. Yet, nursing continues to be categorised as a semi-profession and it has been suggested

that the nursing profession can only ever be a semi-profession since it could at best be only partly autonomous (Etzioni, 1969; Katz, 1969; Lembright, 1983; Dent, 2003; Ayala et al. 2014).

To understand the meaning of a “semi-profession”, it is useful to first of all define the key concept of a “profession” and the term “professionalisation” or the ‘professional project’. Initially the main concern within the literature on professions, up until the 1970’s approximately, was to define what a profession is and what its main characteristics constituted. This early period focused on typologies and case studies to classify the main features, and thereby sought to identify which occupational groups could be granted the status of a ‘profession’. Such trait-based approaches are typically focused on identifying the traits that make up the ideal prototype of a profession. Various sets of criteria have been suggested by different authors. For example, du Toit (1995, p. 165) identifies ten most important characteristics of professions (see table 3).

**Table 3.1: Characteristics of a full profession**

1 the profession determines its own standards of education and training,
2 professional practice is often legally recognized by some form of licensure,
3 licensing and admission boards are serviced by members of the profession,
4 most legislation concerned with the profession is shaped by the profession,
5 the occupation gains in income, power and prestige ranking, and can demand higher-calibre students,
6 the practitioner is relatively free of lay evaluation and control,
7 the norms of practice enforced by the profession are more stringent than legal controls,
8 members are more strongly identified and affiliated with the profession than are members of other occupations with theirs,
9 the profession is more likely to be a terminal occupation, members do not care to leave it, and a higher proportion assert that if they had to do it over again they would choose that type of work,
10 the student professional goes through a more far-reaching adult socialization experience than the learner in other occupations

Source: du Toit, D. (1995, p.165)

The general consensus in the literature about the key characteristics of a profession echoes this set of features. Indeed, the term ‘profession’ is often utilised to define occupational groups typically characterised by a high status (Abbott and Meerabeau, 1998). A full profession is associated with an organised body of experts who are in the position to apply abstract knowledge to particular cases (Abbott, 1998; Abbott, 1988) and even to monopolise their expertise. Elaborate systems of instruction and training alongside formal and explicit prerequisites (including examination) for entry are yet further characteristics of a full profession. This serves to create a social boundary around the profession whereby it distinguishes itself from and excludes other occupations. They are also thought to possess a code of ethics that guides behaviour and to rely on fees for services regardless of success or failure of that service. Trait-based theories furthermore emphasise the ideology of public service and altruism that are ascribed to the ‘full’ profession. Professional autonomy – the right of the profession to define and control its own work - is an important aspect in any such characterisation. In fact, it is

suggested to be *the* defining attribute of a profession (Culbertson and Hughes, 2008). According to Abbott and Meerabeau (1998, p. 3) “the professional autonomy is justified by the self-policing mechanisms constructed through their own internal criteria of standards maintained by the profession itself”. As such, professional autonomy is not impeded by managerial authority or control. Du Toit (1995) furthermore refers to the professional socialization process as an important mechanism, which involves the internalisation of the values and norms of the profession. Prime examples of this concept of a ‘profession’ were traditionally found in law and medicine (Abbott, 1998). This description of characteristics however is based on an idealised conception and it is acknowledged that no one profession can fully meet all of these criteria.

Subsequently there was a shift in attention towards the so-called process of professionalisation or the ‘professional project’ (e.g. Abbott, 1988; Abbott and Meerabeau, 1998; Larson, 1977). This refers to the process by which occupational groups aspire to reach the professional status. The analysis of this process has become the key subject of analysis after the 1970s. Wilensky (1964) describes five stages of professionalisation: the emergence of an occupational group, establishment of a training and selection programme, formation of a professional association, development of a code of ethics, and political activity to establish recognition and protection of professional work (Colyer, 2004). While this perspective is a distinct approach to looking at professions, it echoes some of the criteria ascribed to a ‘full profession’.

Another relevant concept then is that of a ‘semi-profession’. According to Etzioni (1969) nurses could be classified as semi-professions because “their training is shorter, their status is less legitimated, their right to privileged communication less established, there is less of a specialised body of knowledge and they have less autonomy from supervision or control than ‘the’ profession” (p.v). In contrast to the relatively independent practitioner which is the full professional, members from the semi-professions are described as being “bureaucratically employed, often lack lifetime careers, and do not use (...) knowledge as esoteric as that of law or medicine” (Abbott, 1998, p. 431). Others argue that while it could be suggested that nursing meets many of the above-mentioned criteria of a full profession, the key aspect which it lacks is autonomy (ability to control of the work situation and conditions) (Liaschenko and Peter, 2004). At the same time, it has been suggested that the nursing profession can only ever be a semi-profession since it could at best be only partly autonomous due to the above-mentioned characteristics (Katz, 1969; Lembright, 1983; Dent, 2003) such as for example its position within the hierarchy of the division of labour. Nurses’ training is still shorter than that of a doctor for example, their status is still less legitimated, and their body of knowledge is still less specialist in comparison to that of ‘the’ profession.

An aspect which has been highlighted in the literature relates to the gender issues involved in the distinction between semi and full professionals. Traditionally, this caring occupation has been and continues to be predominantly occupied by females whereas roles associated with the 'full' profession is predominantly performed by men (medical profession). As Gray (1989) explains, regarding the hierarchy in hospitals of doctor/nurse/patient is based on an ideology of the traditional family hierarchy of father/mother/child. This gender ideology has significant implications for the role and status of nursing. Within this hierarchy, nursing is subordinated to medicine in the division of labour (Turner, 1995; Dent, 2003), furthermore contributing to the state of being a semi-profession. Nursing is often still associated with being merely "womens' work" which indicates the role that gender plays, both in the context of nursing and within notions of 'professions' (Lembright, 1983; Dent, 2003) and the "importance of gendered value hierarchies that persist across cultures and societies (...)" (Müller, 2009, p. 4). That is why, in many cases, the public image of nurses and level of prestige has not changed in line with developments made towards professionalisation due to negative gender stereotypes (e.g. Bridges, 1990; Warner et al., 1998; Ten Hoeve et al., 2013; Manzano-Garcia and Ayala-Calvo, 2014).

#### *Level of professionalisation and degree of convergence*

Overall, the concept of full versus semi-profession is important but the process of professionalisation is certainly a dynamic one (Abbott, 1998). As Abbott (1998, p. 433) puts it: "The system of professions is (...) a world of pushing and shoving (...) professions and semi-professions alike are skirmishing over the same work (...) There is thus no sense in differentiating professions and semi-professions; they are all simply expert occupations (...)" (Abbott, 1998, p. 433). Yet, the consideration of the position of nursing and their relative 'degree of professionalisation' is an important one because this might affect the nature of PA and its consequences and hence the extent of convergence (Boselie et al., 2002). More specifically, it is suggested that the more professionalised an occupation is, the less scope there is for unilateral employer approaches and for the employing organisation to adopt a range of HR practices, including certain types of PA or performance-related pay because such practices "will all be discussed among the professionals themselves, very often stimulated or facilitated by the professional membership association (...)" (Paauwe and Boselie, 2003, p. 63). In other words, the formal education, training and membership of professional bodies/associations play an important role in forming professional norms, values and expectations (DiMaggio and Powell, 1983) which might limit the scope of hospitals in their use of certain HR practices, especially those that serve as management control systems. In relation to HRM practices, including PA,

specifically professional bodies can potentially play an important role. Indeed, many authors note that regulatory and professional bodies can represent constraints for management in the adoption of HR practices whether in relation to recruitment and selection, training and development or PA (e.g. Truss, 2003; Cogin et al., 2016). For example, professional associations might facilitate professionals to engage with the subject of PA and contribute to the forming of an overarching opinion or position on the matter, for instance by publishing position statements or guidance documents in relation to appraisal.

It is recognised that nursing has engaged in attempts of professionalisation (Abbott and Meerabeau, 1998) and advances within nursing have been made. The literature indicates several ways in which nursing has pursued professionalisation across countries such as in the area of education, through increased scientification and academisation alongside the systematisation and further development of specialist knowledge, the regulation of educational pathways, and the control of education courses, exams and admission control and the use of nursing protocols and guidelines (Friesacher, 2009; Ten Hoeve et al., 2013). In relation to education, EU level regulations regarding the general requirements for the training and education of general nurses has led to increased harmonisation of e.g. contents of training (see e.g. Keighley, 2009), which arguably further contributes to shared values and principles and strong professional norms within nursing. Moreover, the Bologna process implies a trend towards higher education for nurses which is equally the subject of standardisation processes across the EU (Collins and Hower, 2014; Davies, 2008). In addition, a general trend across Europe is the specialisation in the profession, i.e. the development of different specialities in nursing, a classic professionalization strategy, although the number of specialities still varies between countries.

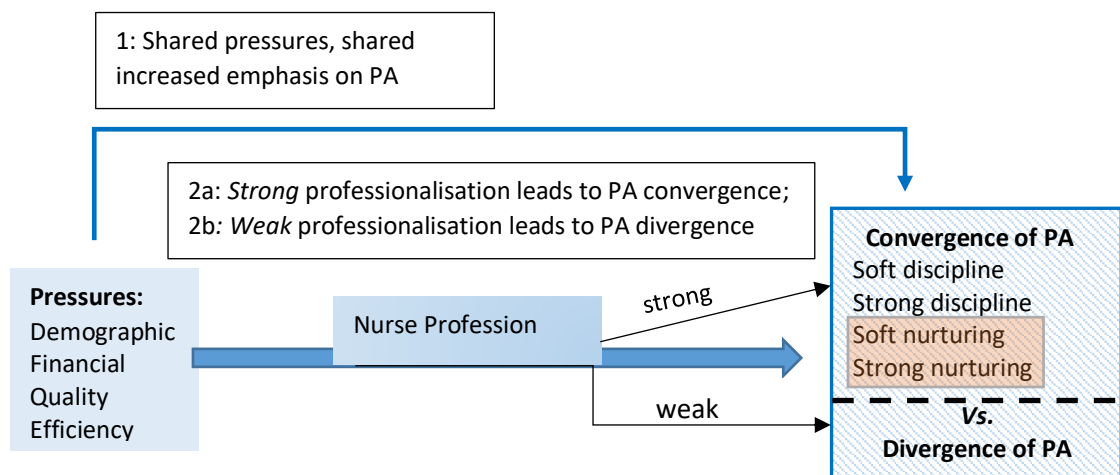
The nursing literature, and according to Ayala et al. (2014) the evaluation of nurses' professional standing and its categorisation as a semi-profession, has the implicit assumption that nursing in different countries has developed homogenously and nowadays has achieved "similar degrees of recognition" (p. 1). Overall, given the advancements made, this is why some argue that categorising nursing as a semi-profession is somewhat misleading (e.g. Apesoa-Varano, 2007) and as such there may indeed be scope for nursing to influence PA practices. Based on this, it could be expected that a higher level of professionalisation amongst nurses on the basis of shared values and principles leads to similar approaches to PA, i.e. convergence, in different countries. In terms of the type of PA, a high level of professionalisation can be suggested to lead to PA being developmental with high levels of discretion and scope for professional autonomy rather than discipline-orientated [proposition 2 - strong version] as highlighted by the orange sub-box under 'convergence of PA' in figure 3.2.

However, other authors emphasise that nursing is still an incomplete profession. Manzano-Garcia and Ayala-Calvo (2014) identify in their SWOT analysis that across Europe, nursing is said to have an overall weak professional identity as it is deeply rooted in the notion of nursing being a ‘calling’ and to continue be deficient in independence. Koff (2016) also highlights the marginalised position of nursing. All this has led to a situation where nurses in Europe are often prevented from being in positions where decisions are made for the profession (Manzano-Garcia and Ayala-Calvo, 2014). In relation to PA then, it could be proposed that the position of nursing is yet such that it has limited direct influence over PA. More broadly, there are suggestions that in relation to public management reforms nursing is likely to be more vulnerable than other ‘full’ professions (Ferlie, 1999), an argument which might be extended to PA as semi-professionals are likely to be less able to influence such practices in comparison to the elite professions. In consideration of these assertions, it is expected that when nursing can be characterised as “weak” in terms of its professional status, this leads to more scope for divergence in PA practices across and within countries [proposition 2 – weak version]. This is because other country-specific national institutions then have more scope to moderate the impact of shared cross-national pressures. These two potential outcomes in relation to the nursing profession are indicated in figure 3.2 and illustrated by the ‘weak’ and ‘strong’ arrows respectively, with the former leading to divergence and the latter to convergence in PA.

**Proposition 2a [strong version]:** *A high level of professionalisation among nurses on the basis of shared values and principles, leads to similar approaches to PA in different countries].*

**Proposition 2b [weak version]:** *A low level of professionalisation provides more scope for variation [weak version].*

**Figure 3.2: Proposition 2 – Convergence via strong professionalisation Vs. divergence due to low levels of professionalisation**





However, the extent to which nursing is able to directly shape the character and thus consequences of PA is unclear and a research area which still needs to be tackled, particularly given nursing's "ongoing attempts to professionalize" (Kessler et al., 2015, p. 738) and constantly evolving nature (Marrelli, 2006). Therefore, this thesis considers in more detail in how far PA practices may be affected by the 'semi-profession' of nursing and give due regard to nursing's *current* status in the countries under investigation.

As reflected in proposition 2, depending on the state of nursing there are two main potential outcomes for PA, either convergence or divergence. The first possible scenario is that nursing across countries has achieved a high degree of professionalisation and is able to influence PA practices, thereby contributing toward *convergence* [proposition 2 – strong version]. Secondly, it may be that nursing in each country is not 'strong' enough to shape PA due to lower levels of professionalisation. If the nursing profession experiences low levels of professionalisation, then the influence of nationally distinct institutions, discussed in the following section, may dominate to produce varying types of PA. Hence, in this case more *divergence* could be expected [proposition 2 – weak version], unless the shared cross-national pressures override differences from the distinct national institutional context as argued under the convergence perspective. Another potential outcome is that nursing is significantly more 'professionalised' in one country compared to the other and differs in the extent to which it can influence PA. Again, this would signify greater potential for divergence. This thesis considers these options and, while focusing on nursing's ability to influence PA, also takes potential cross-national variation into account, especially given that up-to-date comparative information on nursing is lacking (Burau, 2013; Camaño-Puig, 2005; Koff, 2016).

In summary, this section argues that nursing shares many features within Europe, including its status as a semi-profession. Furthermore, it is argued that the key question is whether nursing's level of professionalisation has advanced such that it can influence PA. If nursing has achieved high levels of professionalisation, it is argued that this will lead to convergence in PA practice across countries. Alternatively, if the level of professionalisation is low in the countries under investigation, either in both or one, then this provides scope for country variation due to the influence of country-specific institutions. The remainder of this chapter explores the divergence argument and thematises the role of national institutional factors on HRM-related practices and specifically on PA. It is thus concerned with the core research question of if, how and which distinct national institutions shape approaches to PA.

### 3.2. Divergence: The Contextual perspective and institutionalism

The divergence paradigm, which is in line with the so-called contextual perspective, posits that organisations are deeply embedded within their specific national institutional context (e.g. Powell, 1998; Whitley, 1999; Hall and Soskice, 2001). This means that not all HR practices are equally suited for any given context and, by extension, it is therefore unlikely that organisations would adopt the same set of practices or adopt them in the same way (Meyer and Rowan, 1977) across countries. Within the contextual approach the focus lies on the relationship and interaction between the organisation and its wider external environment and how this produces different HRM systems and practices (Martin-Alcazar et al., 2005). It seeks a broader understanding than the universalist perspective and considers the uniqueness within different contexts and centres around questions concerned with the ‘why’, e.g. why something is unique (Dewettinck and Remue, 2011).

Within the divergence or non-convergence perspective the ‘institutionalist school’ is often highlighted (e.g. Pudelko and Harzing, 2007) which emphasises the wider institutional environment as the core determining factor in relation to the character of not just organisations but also their practices (e.g. Powell and DiMaggio, 1991; Scott, 1995). Indeed, many authors highlight the importance of these nation-specific institutions and point out that while at a distance seemingly similar practices are adopted, at local level these institutions produce varying approaches (Goldfinch and Wallis, 2010; Dewettinck and Remue, 2011; Tempel and Walgenbach, 2007; Muller-Camen et al., 2011). Thus, although there might be global trends and commonalities across EU countries, national institutional frameworks still shape the way in which HRM practices are “translated” (Meyer and Hamerschmid, 2010). More broadly, in relation to NPM-reforms, there is a general acknowledgement that such reforms have been wide in their reach in public sectors across countries, but there is an increasing view that important persisting variations remain between countries regarding the scale, speed and pace of the adoption of NPM-associated practices due to distinct national contexts and associated traditions (Pollitt et al., 2007; Painter and Peters, 2010; Pollitt and Dan, 2011; Proeller and Schedler, 2005; Bach and Bordogna, 2011). Overall, differences in the institutional frameworks are expected to limit convergence of organisational practices, including HRM practices such as PA, significantly under this perspective. The focus in this thesis lies on this institutional perspective, given its explanatory power (Brookes et al., 2011; Maley, 2013). Indeed, Kirkpatrick et al. (2009) highlight that the ideas behind institutional theory are particularly relevant to the health service, with a range of studies confirming the importance of embedded institutions that lead to variations

between countries (e.g. Dent 2006; Burau and Vrangbæk 2008) such as for example in terms of managerial systems and HRM practices (Gooderham et al., 1999).

It should be noted that there are differences, or rather distinct emphases, depending on the specific approach to institutional theory or 'institutionalism' (i.e. the study of institutions) which is related to the fact that this approach has been adopted in various disciplines namely in economics, political science, including public policy studies and comparative politics, social science and other disciplines (Peters, 2000; Barzelay and Gallego, 2006). As a consequence, variations in relation to institutionalism emerged. Different authors use different ways of categorising these versions. Frequently, it is distinguished between at least three forms of institutionalism: rational choice institutionalism (RI), historical institutionalism (HI) and sociological institutionalism (SI) (Hall and Taylor, 1996; Thelen, 1999; Sisson, 2007; Schmidt, 2006; Sorensen, 2017; Morgan and Hauptmeier, 2014; Maggetti, 2012; Barzelay and Gallego, 2006; Peters, 2000; Thoenig, 2003). Overall, it can be suggested that these different approaches to institutionalism are complementary rather than contradictory, that their 'boundaries' are often blurred and that their main difference lies in their respective emphases (Godard, 2004; Hall and Taylor 1996; Maggetti, 2012; Morgan and Hauptmeier, 2014).

All variants of institutionalism share common features such as a concern for the role of institutions for explaining certain phenomena as well as the question of why and how institutions emerge and the processes by which they change (Maggetti, 2012). Each of these versions is similar in that they seek to explain processes and their associated consequences at the lower level of analysis through institutions (Amenta and Ramsey, 2010; Barzelay and Gallego, 2006). Although the details of the respective definitions of 'institutions' vary somewhat, most agree that institutions imply generally accepted and relatively robust rules which can be either formal or informal in nature (e.g. Maggetti, 2012; Staniland, 2008; Sisson, 2007). It can thus be broadly distinguished between formal institutions (such as formal laws, legislation, regulations, policies) and institutions with an informal character (culture, norms, values, conventions, mutual expectations) (e.g. North, 1990) which either constrain or facilitate certain actions at the more local level. As Sisson (2007) suggests "all three [versions of institutionalism] emphasise the importance of institutions as 'rules of the game', which not only constrain but also enable social actors in their activities" (p. 12).

Moreover, all three versions of institutionalism highlighted here share the notion of 'path-dependency' and 'lock-in' effects, although there are variations in terms of how 'strongly' the concept of 'path dependency' is viewed, as summarised by e.g. Sorensen (2017) and others (Amenta and Ramsey, 2010; Morgan and Hauptmeier, 2014; Sisson, 2007). Djelic and Quack

(2007) distinguish between a soft version and a stronger version of path dependency. Accordingly, within the 'soft version' path dependency implies that events that have occurred in the past will influence the events that follow. Within the stronger sense path dependency "characterizes historical sequences in which contingent events set institutional patterns with deterministic properties in motion" (Djelic and Quack, 2007, p.161-162). Here the emphasis is on 'deterministic', i.e. the deterministic effect of institutions once set up, given the "increasing returns" processes and effects (Pierson, 2000). Hence, the costs of reversing a particular path are argued to be very high (Pierson, 2000; Levi, 1997).

Whichever version is considered, in any case, the path dependency argument suggests firstly, that one can differentiate among different path trajectories and secondly, that neither organisations and organisational practices nor the evolution of institutions themselves necessarily follow a 'logic of effectiveness', as argued within the universalist perspective. Hence, institutional theory largely assumes that national institutional environments are relatively stable and their 'paths' would solely experience incremental changes unless there are 'critical moments' or shocks (e.g. fall of communism) which opens the possibility for paths to diverge. According to the 'strong' view of path dependency moments of change is rare due to the "stickiness" of institutional legacies (Murrell, 1995). However, more recently (see Streeck and Thelen, 2005; Thelen 2003) it has been suggested that change can be gradual and transformative through mechanisms such as institutional conversion and layering, where new institutional arrangements are "layered" upon pre-existing ones. Yet, the general argument is that institutional settings are slow to change (e.g. Brewster, 2006) and have enduring effects on organisations and their practices including HRM practices such as PA.

For the purpose of this thesis, the focus is primarily on the HI approach as it is comparative in nature and emphasises the country level and the embeddedness as well as endurance of distinct national institutions across different types of countries and their implications (Tempel and Walgenbach, 2007). Arguably, it therefore represents the divergence perspective best. Under this perspective, despite international pressures, national institutional frameworks will continue to vary between nations due to their strong path dependency and therefore the implementation and respective outcomes of any action - whether in relation to reforms, specific organisational practices and/or HRM practices, including PA - will be influenced by the distinct characteristics of the institutional environment and contribute to variation between countries (Crouch and Streeck 1997; Streeck and Thelen 2005; Maggetti, 2012). Importantly, HI largely rejects the notion of convergence and focuses on cross-national variation.

One key exemplification of the HI approach, specifically within the field of international comparative management is the so-called ‘varieties of capitalism’ [VoC] model by Hall and Soskice (2001) which argues that divergence will persist in different ‘varieties’ of capitalism (Morgan and Hauptmeier, 2014; Allen, 2004; Mayrhofer and Brewster, 2005; Pudelko and Harzing, 2007). Having said that, the VoC approach also shares similarities with RI and indeed is “quite close to the rational choice approach” (Morgan and Hauptmeier, 2014, p. 196) given important intersections between HI and RI (Katznelson and Weingast, 2005). The next subsection briefly explains the underlying premise and notions of the VoC model and how it fits with this thesis in guiding the cross-country comparison of PA.

### 3.2.1 Varieties of capitalism

The VoC approach emphasises the importance of formal and informal national institutions and suggests that there is little scope for convergence across countries regarding (HR) management practices. The VoC framework is one of the most influential models in comparative institutional analysis (Witt et al., 2017). Yet, there are “calls for more work on HRM that uses the (...) comparative capitalisms literature (...) as an analytical base” (Wood et al., 2014, p. 1; Delbridge et al., 2011). Given the research concern of this thesis, namely the comparison and examination of the influence of national institutions upon PA, and the congruent focus of the VoC model on distinct national institutional settings, this model is deemed a useful basis.

The VoC approach is based on the premise that the legal system but also the history and culture of a nation are important factors which influence the ways in which organisations behave. It thus acknowledges the historical dimension of institutions but also that once set up, they are key in generating actors’ preferences and, more broadly, emphasises the strategic interaction of actors in different contexts (Katznelson and Weingast, 2005; Morgan and Hauptmeier, 2014) who seek to advance their interests (Hall and Thelen, 2009), thus reflecting both HI and RI.

At the same time, VoC assumes strong path dependency and a rather fixed institutional setting and argues that countries will continue to exhibit institutional differences, which influences the way in which organisations deal with so-called coordination problems, i.e. how they manage their relations with other actors (e.g. other organisations, employees, trade unions or various associations). VoC also recognises that organisations seek to act in ways which is, and adopt practices which are, considered ‘appropriate’ (Hall and Thelen, 2009) in the specific context. This in turn gives rise to differences in e.g. the nature of employment relations, ideologies management practices (Dalton and Bingham, 2016; Hall and Thelen, 2009). Overall, previous research focusing on multinational corporations seems to support this assertion and finds that

depending on the specific 'variety' of capitalism, HR practices differ as these are affected by this broader institutional set-up (e.g. Farndale, Brewster, and Poutsma, 2008).

The VoC framework differentiates between two main ideal-types, namely liberal market economies (LMEs) and coordinated market economies (CMEs). The CME vs. LME distinction implies a spectrum on which, it is argued, it is possible to locate most countries, so not all countries represent these 'ideal' types completely and would vary to the degree they do. Typically, it is said that LMEs and CMEs differ from one another in relation to five main spheres namely: Industrial relations; education and training; corporate governance; inter-firm relations and relationship with employees (Hall and Soskice, 2001, pp. 21–36). Overall, LMEs represent market-based and CMEs relationship-based form of coordination across these dimensions. The prime example used for the former is the US or UK and for the latter it is Germany (Hall and Soskice, 2001).

LMEs can be summarised by the following characteristics: the labour market is less regulated which also implies less employee protection. There is more labour market flexibility and as a result more employment types and a higher degree of individual contracting. Trade unions are weaker and there is less scope for social partnership. Bargaining at firm level is preferred to other forms of collective bargaining. Due to the decentralised industrial relations system which is characteristic of LME, it is said that employers have considerable choice in terms of their HR and work practices and e.g. pay in the context of low trade union density. Lower levels of worker participation is typical for LMEs. Inter-firm relations are competitive. Furthermore, LMEs are associated with generic tertiary skills bases (rather than vocational skills). There is a higher incidence of income inequality however also more rapid innovation.

Conversely, CMEs are associated with cooperative, long-term interfirm relations, industry-specific skills bases, stronger national labour movements, more developed plant and/or industry-level bargaining, and co-determination structures at workplace level (Wood et al., 2014). In theory, negotiation plays a greater role in CMEs, which is characterised by a more centralised industrial relations system and where, through the power of trade unions and WCs, HR practices and pay are subject to negotiations (Batt et al., 2010). Thus, regarding HRM in particular, the choice of management practices in organisations in CMEs is more controlled due to high levels of regulation, in comparison to those located in LMEs.

### *Within-country variation?*

A concern often articulated in relation to the VoC model is that it does not pay sufficient attention to the role of agency and 'strategic choice', i.e. different ways in which organisations might respond to the same institutional pressures. Indeed, the VoC framework has been criticised for ignoring the complexities and differences *within* the two dominant market systems it identifies (Pendleton, 2009; Bechter et al., 2012; Lane and Wood, 2009). According to Crouch (2005, p. 32) the VoC model "allows the firm virtually no autonomy (...)" and thus does not account for managerial discretion or acknowledge that organisations can differ in their ways of working. Instead, Crouch (2005) highlights the VoC model's obsession with national patterns and with trying to categorise empirical details into its ideal dichotomy (LME vs. CME) rather than exploring the forces which operate within cases. Relatedly, a key weakness of the VoC model is that it is inflexible due to the rigid view on path-dependence which connects to the neglect of the issue of institutional change. As Crouch (2005) notes, the VoC model does not make any provisions for heterogeneity or changes in characteristics. It thus largely ignores within-country diversity and variation within national models and the potential for actor agency and institutional changes.

However, the institutionalist perspective more broadly does not preclude the "agentic and often creative ways in which organizations inculcate and reflect their institutional environments" (Suddaby, 2010, p. 15). As Boon et al. (2009) claim, institutions and the pressures they exert can be mediated within the organisation as there is scope for strategic choice even in highly institutionalised environments. Managers can still play an important role in the interpretation and decision-making processes involved. Thus, organisations can still respond in different ways to the same institutional pressures, depending on the "organization's internal dynamics" (Greenwood and Hinings, 1996, p. 1032; Oliver, 1991). Consequently, there are different degrees of 'institutional fit' (Boon et al., 2009) due to different ways in which organisations, particularly management, respond to these pressures given the scope for human agency and strategic choice. Leeway can thus be created when choosing HRM practices in organisations although within the parameters of the national context. Therefore, it could be that within 'national' approaches to PA, there is still "leeway" (Boon et al., 2009, p. 495) or "strategic space" (Keizer, 2011, p. 46) for hospitals to adapt their PA systems, giving rise to some variations within countries as well.

While the VoC model predominantly argues for dominant national patterns, likewise, even this approach recognises that there is *some* scope for within-country differences, although more so in the case of LMEs rather than CMEs. According to this perspective, in CMEs achieving

legitimacy with the various stakeholders (such as e.g. trade unions, WCs) plays a greater role for organisations, as their role is underpinned by legislation and is highly regulated. In contrast, in LMEs, where employment regulation as well as employee voice is more limited, organisations have more autonomy and as such there is more “diversity of practice” (Farndale et al., 2008, p. 2008). As Farndale et al. (2008) argue in their comparison of HRM practices between foreign-owned MNCs, domestic-owned MNCs and domestic organisations, it could be suggested that there is more variation in the way in which HR practices are used in LME countries due to the “higher levels of liberalism, and therefore wider range of options in the HRM domain” (Farndale et al., 2008, p. 2009) than in CMEs characterised by higher levels of regulation of HRM practices. This is broadly in line with research conducted by Katz and Darbishire (2000) in the automotive and telecommunications sector in seven different countries, who identify (increasing) variation of employment patterns in each country yet important lasting national differences especially when comparing more versus less institutionalised countries, namely in terms of the degree of variation and how workplace practices are implemented.

This thesis also considers similarities and/or differences *within* each country because this study thereby ‘controls’ for industry (further discussed in chapter 4) and because within-country differences cannot be ruled out (Cooke et al., 2017; Kaufman, 2016). However, the focus is still on national institutional influences and variations given that, particularly in the public sector, the wider institutional context tends to constrain ‘strategic choices’ (Kessler, Purcell and Coyle Shapiro., 2000) and ‘structural constraints’ are particularly relevant in the health sector (Bach, 2004). Hence, the possibility for some within-country variation is acknowledged, meaning that there is scope for some discretion in terms of national models for PA, however within the parameters of the specific national context. Although a detailed examination of institutional *change* is beyond the scope of this current study, it is a limitation which must be borne in mind and which may be particularly relevant to countries like the Czech Republic, classified as transition countries. Furthermore, as explored in the next chapter (chapter 4), although the Czech Republic displays important characteristics of an LME specifically in terms of its employment relations system, it does not represent a ‘pure’ LME variant, indicating the limitations of the VoC model in and its use of two main ideal types.

#### *VoC’s applicability to the public sector*

A core element in the VoC model is the concept of institutional complementarities. This implies that national institutional set-ups have their own institutional logic and, as such, institutions are not only compatible but interdependent to each other, which creates the lock-in effect mentioned above (Godard, 2004; Edwards et al., 2004; Maggetti, 2012). Neither variety of



capitalism is regarded as superior, instead the core issue is to what extent institutions complement each other per the institutional logic of the country (Godard, 2004).

However, the VoC model largely ignores sectoral differences (Bechter et al., 2011) and its primary concern is with the private sector and the industries which constitute the core competencies of a nation, i.e. which represent the nations' competitive advantage. The basic premise is that the institutional set-up in a country affects all sectors. Although the VoC model thereby oversimplifies national differences, still, the framework is useful because it indicates that organisations across countries operate within very distinct contexts regarding their economic, political and societal environments and industrial relation systems which can all have significant implications for the way in which organisations operate.

Therefore, it would be reasonable to apply conceptual basis of this model to the public sector and use it to investigate relevant institutions influencing PA. The VoC framework has previously been applied to the public sector for example to explain divergence in relation to NPM implementation (Simonet, 2011). It has also been applied in the higher education context and it is argued to be appropriate to do so because for the "application of the conceptual tools of the VOC approach, the institutional embedding of the object is more relevant than its organisational character" (Graf, 2009, p. 572). The VoC model is thus useful in terms of its conceptual tools to identify relevant distinctive institutional factors (Graf, 2009) despite its inherent limitations due to oversimplification of national differences and inflexibility regarding institutional change.

In sum, the VoC model, which can be broadly categorised under HI, is a useful conceptual basis for guiding this research and the exploration of the extent to which national institutional factors moderate the shared pressures on healthcare organisations due to the strong comparative focus and emphasis on distinct national settings. The next section discusses key national institutions, focusing on those which are of particular relevance to the public sector and the study at hand, namely the role of specific healthcare and the employment relation systems, with the latter being a key dimension in the VoC model.

### 3.3. National institutional factors

In this section, underpinned on the notions of the VoC model, key national institutions will be discussed. It will be concentrated on those institutions relevant to this research, i.e. which are potentially relevant in shaping the why, how and consequences of PA specifically for hospital nurses in distinct ways across countries. Two main areas are focused on. Firstly, although not specifically addressed in the VoC model, the particular healthcare system and its main characteristic are important in seeking to understand the approaches to PA as it may affect how

the PA practice is treated. Related to this, differences in national systems for external quality assurance of hospitals are argued to have a potential to affect the use of PA. Secondly, country-specific employment relations institutions, including distinct collective bargaining arrangements may have implications for the use of PA and performance-related bonuses. Employee voice mechanisms and co-determination rights is also argued to shape the nature of PA for nurses.

### 3.3.1 Healthcare Systems

#### *Basic characterisation*

Healthcare systems are often broadly classified within one of three traditional broad categories, namely the Bismarck model, the Beveridge model or the Semashko model (see e.g. Haffner et al., 2016; Kutzin, 2010; Beckfield et al., 2013; Saltman and Figueras 1998; Elola, 1996). These categories highlight the key features of different healthcare systems and their respective models of financing and organisation. Despite clear limitations of such broad and oversimplified classifications and variations within these categories (Kaminska, 2013), as Kutzin (2010) suggests such “labels can be useful to convey important political meanings or to reflect a cultural context in which the health system is considered a “way of life” (p. 13). This in turn may ultimately influence the way in which policies and practices such as in relation to PM or PA are viewed and utilised.

Within the Beveridge-style health system, the health services, which are predominantly publicly owned, are tax-funded (general taxation) and the workforce is directly employed by the state. This is in line with the goal of universal access to care and an equitable distribution of resources (Saltman and Figueras, 1998). Funding is highly centralised via state budgets and there is a clear role for government. The UK is an example of this system. In Beveridge style systems the state has also more control in terms of their labour cost and is able to achieve overall lower expenditure as a result in comparison to the Bismarckian healthcare system (Elola, 1996).

The Semashko model is the centralised communist model and implies a dominant position of the state who controls everything in terms of ownership, funding and financing. It is funded through taxation and provides free access, meaning universal healthcare (Beckfield et al. 2013; Haffner et al., 2016). It is similar to the Beveridge model but differs in that within the Beveridge model the medical profession remains independent with general practitioners acting as important gatekeepers in primary care. In the NHS model there is also more scope for private medicine and overall less government regulation than in the Semashko model (Stevens, 2001).

Germany is a prime example of a Bismarck healthcare system. This means that the system is financed through compulsory health insurance fees. In other words, this model is based on statutory social insurance-based systems which are largely funded through compulsory payroll contributions and healthcare services are provided through a mix of public and private providers. Here the state's main role is to oversee and govern the relations between the sickness funds, healthcare providers and customers (Haffner et al., 2016; Beckfield, et al. 2013) with a lot of autonomy granted to the medical profession in relation to the provision of services (Beckfield, et al. 2013). In a similar vein, Böhm et al. (2012) identify Germany as a 'Social Health Insurance type' which implies that healthcare providers, insurer and employer associations, trade unions and patient organisations (i.e. societal actors) all have a great role in relation to the regulation and financing of the system.

The Czech Republic, as a Central and Eastern European (CEE) countries and former communist country, has experienced significant changes in recent decades. Until the revolution in 1989 the healthcare system in such countries was in accordance with the Semashko model. Since the breakdown of the communist regime, the Czech Republic shifted back to its historical roots which were in the Bismarck healthcare system. As such, while the Czech healthcare sector formerly could have been categorised as following the Semashko model, its recent roots lie (as historically so) in the Bismarckian tradition, in that it is primarily financed through compulsory general health insurance (Kinkorová and Topolčan, 2012).

Kaminska (2013) argues that although healthcare systems in CEE countries are frequently categorised as 'Bismarckian' since they have implemented social health insurance (SHI) systems based on social contributions after 1989, important differences remain between SHI systems adopted in Western Europe and in CEE countries. The key difference highlighted relates to the mode of regulation and the role of corporate actors in healthcare governance. According to Kaminska (2013, p. 68) in CEE countries "healthcare regulation is state-dominated, with a weak role of corporate partners" while in Western European countries "corporatist arrangements underlie healthcare regulation". This difference can be attributed to the communist legacies in CEE countries and this difference is still pronounced despite reforms in Western Europe associated with attempts to increase efficiency by increasing competition and government intervention and decreasing the role of corporate partners, which it is argued has not altered the basic character of healthcare regulation. This notion is congruent with the characterisation of the German and Czech healthcare system respectively and is furthermore in line with the logic of VoC insofar that CME countries such as Germany are generally represented by a focus on "regulation (...) characterized by closer integration between legislation, institutions and

stakeholders (...)” and on “balancing the demands of multiple stakeholders in order to achieve legitimacy” in comparison to LME countries (Vaiman and Brewster, 2015, p.157).

Therefore, the Czech healthcare system is in fact currently considered a mixed classification of Semasko/Bismarck rather than purely Bismarck (Haffner et al., 2016). The Czech Republic is identified as an Etatist Social Health Insurance-type healthcare system according to Böhm et al. (2012), which implies that regulation remains the responsibility of the state. In line with Kaminska (2013), Böhm et al. (2012) note that unlike in “traditional social health insurance countries (...), the CEE miss adequate societal actors to whom regulatory powers could be handed over (...)” and therefore their role “remains marginal” (p.26). In all of the CEE countries, including the Czech Republic, the Ministry of Health has a crucial role to play in the governance of funds.

Despite limitations of such broad classification they are still useful as it indicates the importance of path-dependence and the wider cultural and political context within which hospitals and their staff are situated. As the institutionalist perspective would suggest, path dependencies are important here and legacies associated with the respective healthcare system traditions are likely to have an impact on e.g. employment reforms and policies (Hudson et al., 2008) and by extension HRM practices, including PA. As Kessler suggests (2017), institutional differences regarding different national healthcare systems have been quite durable, however if and the way in which these differences feed through to influence HRM practices has not been widely examined as there is a lack of attention paid to institutional contexts in research on HRM in healthcare.

In relation to the notion of path-dependence, the Czech Republic is a particularly interesting case and therefore also considered in this study. As according to Festing and Sahakians (2010) who look at the region of the CEE more generally, whilst research into HRM in CEE countries “remains deficient” (p.204), given “the dramatic political, economic, and social institutional transformation in this region (...), it is necessary to pay special attention to the forces facilitating and hampering the transformation of organizational practices” (p. 204). Depending on the “level of embeddedness of organizations in the old socialist system” (Festing and Sahakians, 2010, p. 204) it could on the one hand be argued that the historical legacy in relation to e.g. the role of government and management and associated features implies a continuing influence. Heitlinger (1999) notes that the situation back then was that under the former totalitarian system “(...) individuals and quality service did not count” (p. 167). Thus, within this former context, and under the Semasko model, a system of PA would have been directly contradictory to these values since it is primarily individualistic in nature and often focused on performance outcomes,

including in terms of service delivery. If path dependency is assumed, this could mean that “organizational inertia” and resistance towards the adoption of ‘new’ organisational practices such as PA will occur (Festing and Sahakians, 2010). So, although formal institutions might have experienced a ‘transformation’, historical legacies continue to influence behaviour (Dalton and Bingham, 2016). On the other hand, assuming that the fall of communism can be regarded as an exogenous shock (Deeg, 2005), which “presents one of the greatest exogenous shocks that European countries have experienced in recent decades” (Saxonberg et al., 2013, p. 438), then changes to the ‘path’ cannot be ruled out.

### *Quality assurance systems*

As mentioned in the introductory part of this thesis, hospitals across Europe are under increasing dual pressures to perform in terms of quality and value for money (Baluch et al., 2013; Pomley et al., 2010). The need to increase efficiency has become paramount in hospitals across Europe as they face pressures to reduce costs (Lindlbauer et al., 2016) while at the same time, hospitals are under pressure to improve and demonstrate quality, particularly in the face of reports of “serious shortcomings in the quality and safety of services and care” (Pomley et al., 2010, p. 1). As a consequence, as established above, the spread of performance management has been identified in the healthcare sector. Furthermore, and increasingly, importance is also being placed on so-called quality management and external quality assurance systems in various EU countries which involves the external assurance of the implementation of so-called standards. This is an implicit element in the VoC literature as one chapter in the seminal book by Hall and Soskice (2001) is devoted to ‘varieties of standardisation’ (Tate, 2001) which is essentially concerned with national approaches in relation to those organisations which are involved in standard-setting more broadly. Even in the case of international standards, evidence from other sectors such as the car industry shows that implementation varies greatly depending on the variety of capitalism, i.e. between LME and CME countries (Hancké and Casper, 1996).

In the healthcare sector specifically, it can be primarily distinguished between two types of external quality assurance: ISO certification and healthcare accreditation (Shaw et al. 2014). According to Shaw et al. (2014): “Both systems share the principle of assessment of all departments of the hospital by an external visitor or team against published requirements or standards that focus on systems for quality and safety management (...) ISO 9001 is a generic standard for quality management systems in any industry, but accreditation standards are specific to healthcare” (p.101). Furthermore, while the term ‘accreditation’ and ‘certification’ are often used interchangeably, the former usually applies to organisations as a whole whereas

the latter can relate to organisations as well as individuals (Alkhenizan and Shaw, 2011). Most often, hospitals are legally required to have internal quality management systems whilst formal external quality assurance is largely voluntary (Lindlbauer et al., 2016). Specifically, accreditation is used as a strategy by which hospitals seek to improve their performance in many countries (Pomey et al., 2010), although hospitals might pursue voluntary external quality assurance for a variety of reasons, such as for internal quality improvement or external marketing, but also as a response to 'external pressure on the uptake of quality improvement by hospitals' (Shaw et al., 2010a, p. 450; Groene et al., 2010).

In relation to hospitals in Europe and external accreditation, Shaw et al. (2010a) and Chatterjee et al. (2016) state that there is variation in approaches between countries. Some countries have no national accreditation programme, whereas others do, and while these different approaches might have much in common there is considerable scope for variation between countries, amongst other things also due to potential differences in interpretation of certain standards (Shaw et al, 2010a; Wagner et al. 2006). Thus, despite the basic logic behind implementing quality management systems and the process of externally certifying or accrediting these systems being similar, and revolving around the idea that hospitals will become safer, these systems vary across countries. As Shaw et al. (2014) claim: "(...) Assessment systems vary across Europe but valid standards and reliable assessments should make hospitals safer even if methods are not consistent (...)" (p.101).

However, what is unclear is the extent to which accreditation standards promote or even require the adoption of individual PA. There are indications that in some countries/regions hospitals are required by accreditation bodies to have a PA system in place, including for nursing staff, such as in Lebanon (El-Jardali et al., 2009), America (Jones, 2007), Canada (Pomey et al. 2010; Lemieux-Charles and Greengarten, 2014) or Australia (Keam, 2011), but information in terms of specific accreditation requirements and the extent to which they demand individual PA in Europe, and elsewhere, is lacking.

In addition, it is unclear which type or approach to PA hospital accreditation promotes, in those cases where the appraisal of staff constitutes a requirement. Comments by Risher (2005) would suggest that PA within the scope of accreditation is likely to result in appraisal practices that are more like a tick-boxing exercise with an emphasis toward judgement and control. Risher (2005) describes the situation like this: "In health care particularly, in which job descriptions are a focus in satisfying the requirements for hospital accreditation, they tend to be lengthy lists of routine job tasks that each worker is expected to perform. The performance appraisal tends to be a check by each task, confirming it was completed. The final performance rating is sometimes

based on the number of check marks” (p.23). This, according to Risher (2005) is in line with the notion and the traditional view of workers who are in need of “close supervision” and who are “predisposed to put forth only the minimum effort” and can “not be trusted” (p. 23) and therefore must be controlled.

Despite indications that hospital accreditation can play a key role not only in terms of whether hospitals adopt PA systems at all but also suggestions that it may potentially influence the very nature of PA, overall little is known about this relation between accreditation and appraisal. Furthermore, although it is acknowledged that there are national differences between accreditation processes in different countries, there is overall little comparative information available and none with regard to its impact on PA practices. Therefore, this study will consider whether potential differences in accreditation systems, which can be considered a national institution, influences the approach to appraisal taken.

### 3.3.2 Employment Relations

#### *Collective bargaining structure*

As described above, the VoC approach illustrates the importance of the wider institutional environment within which organisations are embedded (e.g. Powell, 1998; Gooderham et al., 1999). An important aspect and one of the five spheres highlighted by the VoC framework is the industrial relations system. This includes collective bargaining, a traditional method for employee voice (Dundon et al., 2004; Sisson, 2010). Country-specific bargaining structures might have implications for PA, specifically also in relation to the prevalence and use of performance-related pay or bonuses potentially connected to PA. Therefore, it is important to consider collective bargaining arrangements in the countries and sector under investigation in more detail.

Typically, as highlighted above, CMEs are associated with strong bargaining rights at industry level while in LME countries bargaining rights are typically weak and characterised by fragmented bargaining structures (Doellgast et al., 2009, p. 291). Given the context of LMEs, such as e.g. lower levels of unionisation compared to CMEs, these countries are argued to be more likely to utilise incentive pay practices with a focus on individual performance (Prince et al., 2016) and calculative HR practices more generally (Gooderham et al., 1999). In CEE countries, the generally “more permissive industrial relations system” (Poutsma et al., 2015, p. 291) allows for the adoption of individual performance-related pay schemes in organisations more so than in CME countries. Congruently, the prevalence of such practices is argued to be lower in CME countries, where union coverage tends to be higher and where trade unions and WCs have more

scope to restrict management autonomy, including in relation to the use of various performance-based pay mechanisms (Prince et al., 2016; Batt et al., 2010; Vitols, 2004).

Thus, the importance of national collective bargaining institutions is indicated by a variety of studies, in relation to a range of employment practices, including incentive or bonus schemes, although the focus has often been on private sector firms (e.g. Prince et al., 2016; Doellgast et al., 2009; Poutsma et al., 2015). Overall, the structure of collective bargaining might have clear implications for PA regarding a potential performance bonus component. For example, a public sector-wide collective bargaining agreement could provide a formal scope to introduce such bonus mechanisms in an organised way. Alternatively, collective bargaining arrangements may be silent on such issues, enabling more management choice on such issues.

Overall, differences in bargaining arrangements and employment relations more broadly, is expected to not only shape bonuses but also the prevalence and form PA itself, so that PA in CMEs is more developmental and nurturing whereas in LMEs more discipline-orientated via the use of financial incentives, with greater elements of control and judgement.

Another important element relates to the assertion that the key difference between CMEs and LMEs not just in terms of collective bargaining structures but also worker representation at local level, namely through the WC, and the specific combination of 'dual representation' is crucial in influencing the use and nature of certain HRM practices (e.g. Doellgast et al., 2009), including performance-orientated practices such as PA. The next section briefly considers the role of local employee representative bodies in the form of the WC. Thereafter, the possibility of more direct forms of participation will also be briefly considered.

#### *Employee voice mechanisms*

The VoC model particularly highlights the role of representative voice mechanisms, i.e. indirect worker participation and co-determination structures. Hence, in terms of specific institutional forces, employee voice mechanisms at local level could be of particular relevance when it comes to HRM practices, including appraisal practices (Boselie et al., 2002; Paauwe and Boselie, 2003; Doellgast et al., 2009). As highlighted by Paauwe and Boselie (2003), Rhineland countries, and as according to the VoC approach in CME countries, like Germany (see Hall and Soskice, 2001) are more highly institutionalised than others in terms of the employment relationship. In the case of CME countries, especially Germany, alongside trade unions and relevant legislation, the role of the WC stands out as a significant actor capable of having a direct impact on HRM-related practices (Doellgast et al., 2009). Here, WCs are the key communication channel between trade unions and staff (Jaehrling et al., 2016). While Boselie et al. (2002) focus on the Dutch context



in their cross-sectoral comparative study of hotels, local government and hospitals, the general assertion that WCs are an important stakeholder to consider regarding HRM practices indicates a need to investigate their influence on PA practices.

WCs and their function as a workforce representation body is a historically important institution within the realm of employment relations in CME countries, most notably Germany in both the private and public sectors (Bosch et al., 2012). The rights of the WC usually extend beyond information and consultation rights and encompass strong co-determination rights on various issues (Jevtic, 2012, p. 11; Hölscher and Whitaker, 2004). LMEs typically lack such co-determination rights at local level (Doellgast et al., 2009). Given the differences between LME and CME regarding their co-determination structures and scope for negotiation reflected in the differing role of the WC, one might expect different approaches to emerge in hospitals in such distinct national settings. Certainly, the scope for more control and discipline orientated approaches can be suggested to be greater in LMEs than in CMEs due to the 'productive constraints' (Doellgast et al., 2009) which CMEs industrial relations institutions provide.

Negotiation plays a greater role in CMEs, which is characterised by a more centralised industrial relations system and where, through the power of trade unions and WCs, HR practices and pay are subject to negotiations (Batt et al., 2010). Apart from collective, indirect voice mechanisms such as through the WC, individual and direct means of participation might be used instead when it comes to the adoption of PA practices. These might include e.g. simply regular meetings between management and employees, briefing groups or teams, written forms of communication or other schemes which provide scope for individual employees to make suggestions (Brewster et al., 2014; Marsden, 2013). According to the VoC model, CMEs are characterised by cooperative relations which is particularly supported by voice mechanisms such as the WC. On the other hand, in LMEs more direct forms of individual participation are envisaged to dominate. In a 2007 study, Brewster et al. (2007) found that CMEs were indeed associated with a higher incidence of collective and representative voice mechanisms; rather more surprisingly, they also found that individual and direct voice mechanisms were stronger in such economies (Cooke et al., 2017).

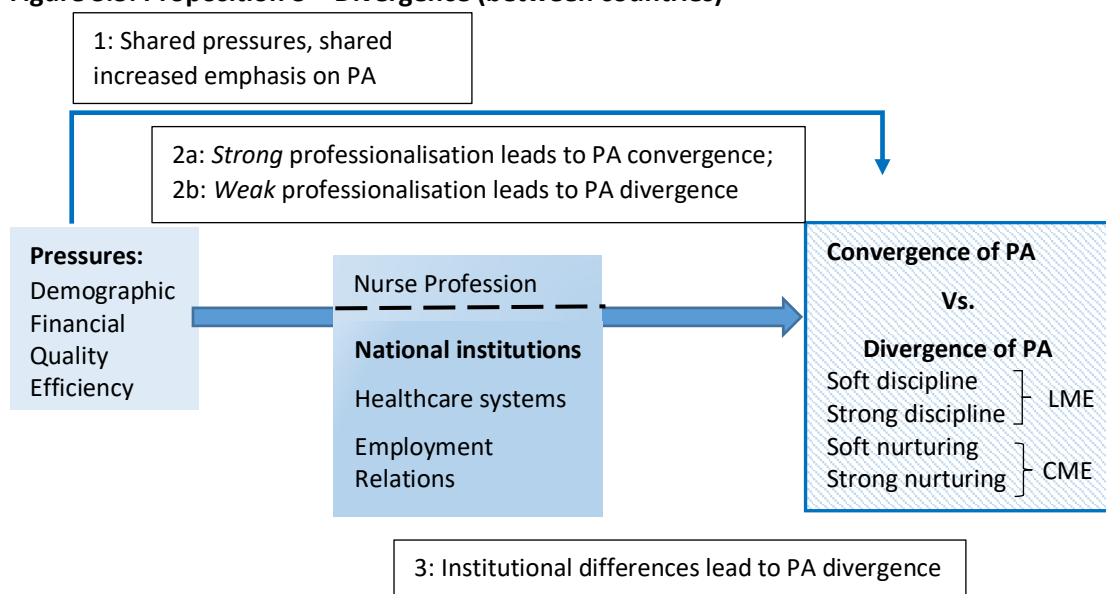
Overall therefore, it would be reasonable to suggest that given the influence of the WC in CMEs, represented by Germany, and the generally more cooperative nature of institutions, PA in hospitals in such countries is likely to be practiced in a more 'developmental and nurturing' manner as these institutions are known to be resistant towards practices which seek performance control (e.g. Kampkötter et al., 2017). Moreover, since WCs are sceptical towards PA systems linked to compensation (Giardini et al., 2005), it is also unlikely that PA would be

tied to financial rewards at the general nurses' level. Furthermore, it has been suggested that in LMEs "contingent reward systems and a range of other calculative (i.e. control-orientated) HRM policies (...) [are] more common" (Cooke et al., 2017, p.201; Poutsma et al., 2006; Gooderham et al., 1999) due to a lack of indirect but also direct involvement. Therefore, in the Czech Republic, a country which is suggested to be characterised as following the LME variant specifically in relation to its industrial relations system, as further explored in the following chapter, hospitals can be expected to adopt more discipline/control-orientated types of PA. However, as discussed above, the extent to which developmental or more discipline-orientated approaches are adopted is also likely to depend on the 'strength' of the profession in question.

In sum, in applying the insights from institutional theory and the conceptual basis of the VoC model to the topic at hand, it is expected that shared pressures are moderated by national institutions, leading to different PA approaches (proposition 3), as depicted in Figure 3.3. The emphasis is, firstly, on the healthcare system because of the focus on hospitals and secondly, on employment relations systems because specifically the public sector stands out in terms of historically distinct employment relations patterns across countries (Bach and Bordogna, 2011). If national institutions are dominant in moderating the impact of shared hospital pressures, then it is expected that in CME countries more nurturing PA types and in LME countries more discipline-orientated types of PA will dominate, as shown in the 'convergence vs divergence' box in figure 3.3. This is expected due to, firstly, the corporatist arrangements which underlies healthcare regulation in Germany (CME), as discussed above, and, secondly, the role of the WC.

**Proposition 3:** *Shared pressures are moderated by national institutions leading to different approaches to PA (in relation to the 'why', 'how' and consequences of PA).*

**Figure 3.3: Proposition 3 – Divergence (between countries)**



### 3.4. Conclusion

The core theme of this chapter was the convergence-divergence debate and exploration of factors which might lead to similarity versus variation in relation to hospital nurses' PA across countries. The first part explored the convergence perspective. On this basis, it was suggested that due to similar cross-national pressures facing hospitals, which has increased the importance of performance management as well as quality management more generally, it would be reasonable to expect an increased shared emphasis on and use of PA (*proposition 1*). The importance of distinguishing between different levels of 'convergence', reflected in the different dimensions of PA, was also considered. According to the convergence perspective, similarity can be expected across these dimensions. Furthermore, the nursing profession and its potential to contribute toward convergence was discussed. In looking at the literature on the nursing profession, *proposition 2* was formulated: a high level of professionalisation among nurses on the basis of shared values and principles, leads to similar approaches to PA in different countries [strong version]. Alternatively, lower levels of professionalisation is likely to contribute toward variation [weak version]. However, given the lack of up-to-date comparative information regarding the professional status of nurses, it is unclear to what extent nursing can directly influence PA practices or indeed whether nursing is equally 'strong' across countries. Therefore, this research gives due regard to the broader situation of nurses in the countries under investigation.

Thereafter, the divergence perspective was discussed. The divergence perspective highlights the importance of context and is in line with institutional theory which argues for enduring differences across countries. On the basis of this view, it is expected that shared pressures are moderated by national institutions leading to different approaches to PA (*proposition 3*). The issue of potential within-country variation was also addressed and suggested to be possible to the extent that national models of PA will allow some discretion within set parameters. Overall, given the differences in institutional settings, particularly in relation to the industrial relations system as well as for example different national systems and interpretations of quality assurance, it could be argued that in 'coordinated market economies' it is likely that 'softer' versions of PA are more prevalent for nurses than in liberal market economies, represented by the Czech Republic specifically in terms of the employment relations dimension.

The next chapter describes and justifies the research approach and methods used to address the propositions formulated in this chapter. It reiterates the research's theoretical basis and explains why the two countries under investigation can be categorised within different 'varieties of capitalism' (Hall and Soskice, 2001). It also presents the various types of data collected.

## Chapter 4: Research Methods

### 4. Introduction

Firstly, this chapter reiterates the theoretical basis of the research and core research aim, namely the investigation of the extent to which shared pressures are moderated by national institutions and how this affects PA approaches across countries. It then highlights how the research problem lends itself to a comparative case study design and how it is applied with regard to the selection and number of cases and overall case study design. Studies that have adopted similar approaches by ‘selecting to difference’ are highlighted (e.g. Caroli et al., 2010).

Thereafter, two key research approaches, namely quantitative and qualitative research, and their respective paradigms are briefly reviewed. The rationale for integrating both approaches is provided. The benefit of a *mixed method* comparative case study design, where the dominant research method is qualitative, is that it effectively addresses this study’s objectives: a comparison of hospitals in the Czech Republic and Germany regarding the ‘why’, ‘how’ and consequences of nurses’ PA. Relevant previous research is presented that has focused on qualitative research to study experiences of PA (McGivern and Ferlie, 2007) and that has successfully combined both research methods (e.g. Redman et al., 2000; Truss, 2001). The justification for the integration of quantitative research methods via a questionnaire is addressed. The relationship of the qualitative and quantitative samples is also commented on.

Finally, the precise research method at each level and for each research question is discussed as well as how the strengths of each approach contribute to the study at hand. Data collected during each research phase is described and the background information of the hospitals in which detailed fieldwork was conducted is provided. The chapter ends with a short explanation of the methods for data analysis.

## 4.1 Theoretical basis, research problem & value of comparative case study design

### 4.1.1 Theoretical basis and country classification

The preceding chapter engaged with debates around convergence and divergence, the theoretical axis of this thesis, and applied these to PA and the study at hand. As hospitals across Europe are under growing pressure to perform due to rising efficiency demands and simultaneous calls for higher quality services (e.g. OECD, 2005; 2011), universalist and rational models would suggest an increased emphasis on PA and similar approaches to PA in hospitals across countries. Furthermore, given the focus on nursing which shares many features across countries, convergence in approaches to PA could be expected.

On the other hand, institutional theory and the notion of 'path dependency' would suggest differences across countries to prevail. The VoC framework, which assumes strong path dependency, predicts differences in organisational practices in CMEs versus LMEs due to their distinct institutional context, an argument which can be extended to PA. Even in EU countries institutional differences can considerably affect the nature of the employment relationship, particularly in the public sector, which in turn affects HRM practice (Almond et al., 2004).

While Germany can be clearly categorised as a CME (Hall and Soskice, 2001), the Czech Republic can tentatively be categorised as an emergent dependent LME (King, 2007) specifically on the employment relations dimension. The original VoC model focuses on the U.S., Japan and Western Europe and does not incorporate countries of East Central Europe. Therefore, some have argued for an extension of the VoC framework (see e.g. Baboš and Klimplová, 2013). Although it might be argued that 'varieties of transnational capitalism' (Bohle and Greskovits, 2007, p. 462) exist when it comes to the transitional states of Eastern Europe, regarding the Czech Republic there have been suggestions that it can best be described as a liberal dependent economy with much resemblance of the LME categorisation (e.g. Crowley, 2008; Heyes et al., 2012). King (2007) extends the VoC framework to include 'liberal dependent post-communist capitalism', a category the Czech Republic is identified to belong to as it is characterised by the "liberal nature of the state and the dependent nature of the economy" (King, 2007, p.2). Two key features are highlighted in this regard. Firstly, it is said that countries of this category have a high lack of working-class political mobilisation and secondly, an outdated technological structure, which makes them more reliant on foreign investment. This assertion is in line with Nölke and Vliegenthart (2009) who extended the VoC framework by including the 'dependent market economy' type of capitalism to highlight the dependent nature of such economies.

Nevertheless, as King (2007) suggests that particularly the employer-employee relationship in such 'liberal dependent systems' is characterised by 'Liberal capitalism' and 'very weak unions' (p.14). This is in accordance with Saxonberg et al. (2013) and Crowley (2008), who state that Czech labour market reforms "went in a clear market liberal direction" (Saxonberg et al., 2013, p.438). Also according to Klimplová (2007) and Baboš and Klimplová (2013), within the realm of industrial relations the Czech Republic is orientated towards the LME type, i.e. following a liberal approach, and it is expected that this trend towards 'liberal principles' will continue in this sphere (Klimplová, 2007; Crowley, 2008). Thus, although the Czech Republic does not represent a pure form of the LME categorisation, and the extent to which it is liberal on other dimensions might be debated given patterns of 'systematic un-coordination' (see Baboš and Klimplová, 2013; Saxonberg et al., 2013), in terms of the employment relations system which, as established in chapter 3, is likely to have particular relevance with respect to the practice of PA, the Czech Republic can be clearly contrasted to Germany. As such, the country cases under investigation represent distinct institutional environments which makes them ideal cases to explore the influence of such institutional factors in shaping PA at local hospital level, with Germany being the prime example of a CME and the Czech Republic, although yet considered a transition country, an emerging LME particularly in the industrial relations sphere.

#### 4.1.2 Research problem and aim

Chapter 2 demonstrated that the nature of PA can vary in the degree to which it is developmental or judgemental and the degree to which it serves to increase managerial control or allows for professional autonomy. While acknowledging that combinations are possible, it has been suggested that this results in four broad different types of PA. Differences in the national institutional context would suggest that PA practice and nurses' experiences of it differs across countries. The counterargument would be that given shared hospital pressures and the focus on general nurses, broadly classified as semi-professionals across countries, similar approaches to PA will emerge.

The aim of this research is to compare PA approaches for nurses in hospitals in the Czech Republic and Germany regarding: 1) why PA is used, 2) how PA is structured, and 3) the consequences, i.e. how PA is perceived by nurses in each country as well as if the 'why', 'how' and consequences of PA are indeed connected. Thereby it seeks to address the propositions developed in Chapter 3 and identify if a) similarities in terms of the sectoral context and pressures will lead to an increased emphasis on PA and similar approaches b) how the level of professionalisation among nurses affects PA (i.e. if high levels of professionalisation contribute toward convergence or lower levels of professionalisation toward divergence) and c) whether

and which institutional factors lead to differences across these dimensions (why, how, consequences). As Yin (2003, p. 11) argues, the use of propositions “helps to focus attention on certain data and to ignore other data” and are thus useful in guiding this research in order to address the related research questions, namely:

**1. *Do shared hospital pressures lead to similar PA approaches?***

**2. *Do differences in the national institutional context lead to distinct PA approaches?***

**3. *What is the overall outcome of (different forms of) PA?***

#### 4.1.3 Comparative case study

The research aim lends itself to a comparative case study approach. As Halperin and Heath (2012) suggest, the comparative case study approach is useful “for identifying and explaining differences and similarities between cases (often, but not always, defined in terms of countries)” (p. 203). Thus, through a comparative case study research approach, it is possible to address the research aim of identifying and explaining differences or possible similarities in terms of the why, how and consequences of PA. In addition to comparing similarities and differences, a comparative case-study research “allows processes and outcomes, generative mechanisms, and conclusions about causes and outcomes to be drawn more effectively (...) [it] helps to clarify both the nature of a mechanism and the range of variation in both process and outcome (...) [and] to clarify the extent to which outcomes are attributable to a mechanism or its context or their interaction ” (Ackroyd and Karlsson, 2014, p. 30-31). In other words, a comparative case study design allows to assess the nature of PA, the way in which it varies across different countries as well as to identify the extent to which these differences are due to the wider context.

#### 4.2 Case selection

##### 4.2.1 Unit of analysis

In this comparative case study, the unit of analysis is the country-level and the goal is to identify systematic differences across nations for hospital nurses, in terms of why PA is implemented, how it functions and how this translates into practice. Each of the two case studies (Czech Republic and Germany) are illustrative of the wider national context and overall policy of appraisal. The hospitals where fieldwork was conducted are illustrative of the implementation of appraisal in practice. According to Hantrais (1999, p. 98) “nation states, afford a convenient frame of reference for comparative studies since they possess clearly defined territorial borders,

and their own characteristic administrative and legal structures”. Examining a particular phenomenon using nations as the contextual framework is useful given the diverse and specific legal, political, economic and socio-cultural systems and therefore, “provide appropriate material for a multilevel analysis” (Hantrais, 1999, p.99).

Indeed, the rationale for choosing two countries and adopting a comparative research design is that different levels of analysis can be merged and cross-national, national and local factors can be linked “in order to explain a particular (...) phenomenon (...) by comparing individuals nested within countries, we are able to examine the impact of country-level factors (such as institutional arrangement) on individual behaviour” (Kaarbo and Beasley, 1999, p. 204). This is what this research attempts to do and therefore adopts a comparative case study approach. By doing so, this study is able to identify wider contextual factors that shape the process of PA and nurses’ experiences of PA within countries, identify similarities and differences across the countries and thereby merge the different levels of analysis.

#### 4.2.2 Most different system design

According to Yin’s (2003) replication logic within a comparative case study approach, each case should be selected so that it either (i) predicts similar results (a *literal* replication) [selecting for similarity] or (ii) predicts contrasting results but for predictable reasons (a *theoretical* replication) [selecting for difference]. This study follows the latter approach which implies the selection of cases which are different from each other in theoretically significant ways and the expectation that different processes or outcomes emerge, which is followed by an investigation of the how and why.

As has been established, the country cases are selected on the basis that they differ in many important aspects, including on important dimensions of the VoC model, in particular the employment relations system, as well as e.g. their legal and regulatory frameworks, and their political, economic and socio-cultural systems and most probably their “national rules and understandings” (Almond et al., 2004, p. 599) which is expected to lead to variations regarding nurses’ PA. Germany and the Czech Republic are being chosen as they represent different classifications (see above) and distinct institutional contexts. They are thus theoretically important countries as they differ on a range of relevant aspects related to the national level, allowing for a most different system design approach. Given the background of the Czech Republic, as a country still classified as being in transition following the fall of Communism in 1989, one might expect yet further differences to emerge compared to Germany with regards



to PA. Research within the Czech public services is overall limited, and thus there is a unique opportunity in taking the Czech Republic into consideration in the scope of this research.

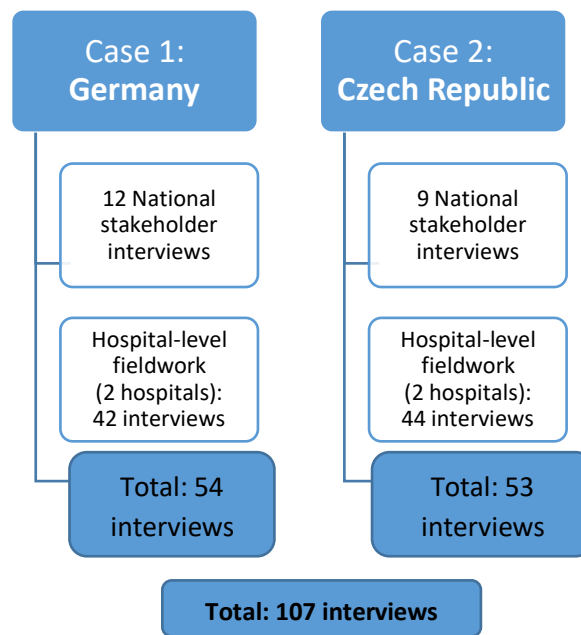
A study which adopts a comparative case study approach by Easterby-Smith et al. (1995) considers variations in HRM however both between as well as within different countries, namely the UK and China by conducting a direct comparison of practices in matched Chinese and UK companies (four per country). Easterby et al.'s rationale for looking at the UK and China is similar as to the one provided here, namely because they differ markedly in terms of their institutional context. Companies for comparison varied regarding industry [metal processing, oil, chemicals and the manufacturing of construction materials] but were similar in size and in that they were all from the process industries. The main method of data collection was the use of interviews with a cross-section of managers in each company and employees, supported by internal documentation and guidelines. The cross-country comparison enabled Easterby et al. (1995) to conclude that the countries differed especially in the 'softer' areas of HRM such as appraisal, reward system and stance towards union management whilst in the other areas of HRM differences were more pronounced within the two countries.

While chosen cases must be sufficiently different on relevant dimensions (Seawright and Gerring, 2008), to be able to make useful comparisons selected cases should neither be completely the same nor completely different (Kaarbo and Beasley, 1999, p.380). The country-case studies are therefore selected in such a way that other case and sample characteristics, such as occupational group (general nurses) and organisational context (public sector hospital of equal size faced by similar pressures), and the number and characteristics of the hospitals are as similar as possible (see section 4.5). Keeping these characteristics constant means that any differences in PA can be attributed more confidently to country influence (Blatter and Haverland, 2012).

The study by Caroli et al. (2010) adopts a selected-to-difference design in a similar way as this study does. The phenomenon under investigation in the study by Caroli et al. (2010) is the workplace practice of numerical and functional labour flexibility and the country cases subject to comparison France (seven) and the UK (six) in the food processing sector, which has been under similar competitive pressures. Having controlled for the sector, Caroli et al. (2010) were able to conclude that differences in the institutional and regulatory environment contributed to variations regarding the predominant forms of flexibility across the two countries more effectively. A similar approach is adopted in this study: by incorporating two public sector hospitals per country, the industry or sector is effectively controlled for in the examination of differences.

As according in the words of Cooke et al. (2017, p. 198), what this study seeks to do is to “draw out (...) differences in dominant national HRM paradigms or recipes” in relation to appraisal. However, as discussed, national models of PA might still be permissive to adaptation as there might still be some strategic leeway. Therefore, by incorporating two hospitals cases within each main national case, this is an aspect this study accounts for.

**Figure 4.1: Number of interviews conducted for case 1 and case 2**



#### 4.2.3 Number of cases

An issue within comparative case study research relates to the potentially problematic trade-off between intensity and breadth, which is likely to vary depending on whether one adapts a large N-study (N relates here to the number of cases or countries), a small N-study (involving the analysis of a small number of cases, e.g. 2, 3 or 4) or a single N-study (Kaarbo and Beasley, 1999).

This study mitigates this issue by concentrating on an ambitious yet manageable number of two country cases. Benefits of small-n studies include that while providing scope for contextualisation, cases can be analysed in-depth as it enables “the researcher to investigate a much larger number of contextual or microvariables than is feasible in large-scale multinational studies” (Hantrais, 1999, p.99). This is why this research focuses on two country cases, which allows for an in-depth exploration of the nature of PA at hospital level, comparing also the individual hospital cases, as well as comparison between the country cases by taking the wider context and potential influencing factors into account.

As mentioned above, each of the two case studies (Czech Republic, Germany) are illustrative of the wider national context and overall policy of appraisal (based on national stakeholder interviews and documentary evidence), and the hospitals investigated within these cases are illustrative of 'appraisal in action' at the hospital level. As such, this study is concerned with 'analytic generalisation' rather than statistical generalisation (Yin, 2003, p.32). Again, the incorporation of two hospitals per case allows firstly, to 'control' for the sector and to establish the aspect of whether national models of PA are still permissive to variation and adaptation.

### 4.3 Research approaches

Traditionally it has been differentiated between two main philosophical stances or paradigms that underlie management research methods and designs: the positivist (objectivist, deductive, empiricist) and non-positivist (subjectivist, inductive, interpretive) view. The latter has also been termed social constructionism (Easterby-Smith et al., 2002; Doyle et al., 2009, p. 176). These two paradigms are argued to differ in terms of their epistemology (how we know what we know; belief about how something can be studied), ontology (assumptions about the nature of reality), axiology (values) and methodology (the process of research). In short, the view or paradigm adopted is argued to greatly influence the research questions posed and methods used, including data collection and analysis (Brannen, 1992). Positivism is associated with quantitative and social constructivism with qualitative methods of research (Doyle et al., 2009). Each research approach offers distinct strengths and weaknesses (Sanders et al., 2014), which are briefly considered below, after a short description of what these approaches entail.

#### 4.3.1 Positivism & quantitative research

Easterby-Smith et al. (2002) state that positivism, implies the notion that "the social world exists externally, and that its properties should be measured through objective methods, rather than being inferred subjectively" (p.28). Positivism can thus be said to be based on the ontological assumption that reality is external, existing independently of researchers, and objective. As a result, the emphasis is on observable, empirical and quantifiable facts (epistemological assumption) in an effort to generate universal conclusions (O'Mahoney and Vincent, 2014).

Within quantitative research, variables are typically isolated and clearly defined and then linked together to propose a set of hypotheses prior to data collection. According to Brannen (1992) quantitative research is concerned with enumerative induction. Thereby, it 'abstracts by generalizing' (p.7). Hence, quantitative research looks at many, many cases for similar characteristics and then abstracts them (conceptually) due to their generality.

The quantitative approach is said to rely on numerical data to test particular relationships between variables and theories about reality. Its focus is on cause and effect, and the determination of the magnitude and frequency of relationships (Migiros and Magangi, 2011). The main quantitative research designs include experimental, quasiexperimental, and correlational and survey research designs (Migiros and Magangi, 2011).

#### 4.3.2 Social constructivism & qualitative research

Social constructivism posits that “‘reality’ is not objective and exterior, but is socially constructed and given meaning by people (...)”, and as such “focuses on the ways that people make sense of the world especially through sharing their experiences with others” (Easterby-Smith et al., 2002 p. 29). In fact, O’Mahoney and Vincent (2014) suggest that constructivist claim that it is impossible to have “‘true’ knowledge of an external ‘reality’” (p.5) since people determine ‘reality’ through their construction of a subjective meaning. Therefore, the key aim of this research approach is to understand the different meanings people place upon their experience and explain why they differ by focusing on the identification of discourses and narratives.

Within qualitative research, concepts are defined more broadly and are subject to changes during the course of the research and data collection. Rather than confirming or disconfirming hypotheses and looking at a pre-specified set of variables, qualitative research takes a broader view and seeks to find “patterns of inter-relationships between a previously unspecified set of concepts” (Brannen, 1992, p.4). Hence, qualitative research can be associated with analytic induction, where the main purpose is to test theory rather than infer and generalise findings. Analytic induction ‘generalizes by abstracting’, which means that, qualitative research abstracts from a concrete, specific case and generalises the case’s characters. Qualitative research is associated with a range of research designs, including: phenomenology, ethnography, grounded theory, discourse analysis, narrative analysis, case studies and also different data collection strategies such as interviews, observation, focus groups, fieldwork etc.

#### 4.3.3 Key strengths and weaknesses

The key goal and strength of quantitative research is its ability to test theories, make statistical inferences and generalise its findings to other populations, as the findings reflect the overall population more accurately (VanderStoep and Johnson, 2009). However, there are important limitations regarding quantitative research which are particularly relevant to this study’s objectives. As according to O’Mahoney and Vincent (2014, p.4) quantitative research “rather disregards the independent role(s) of broader context(s), which social phenomena cannot arbitrarily be separated from (...) positivists and empiricists (...) can only describe, but not

explain, empirical events”. While quantitative research might be able to correlate variable A to variable B, the question of how these two phenomena relate to each other remains unexplained. Even if a causal relationship between two variables can be discerned, the conditions under which this is the case are less clear. For example, there might be a range of contextual factors that influence such a relationship such as institutional arrangements, employment regulation, and cultural norms. As such, quantitative research is particularly suited to answer ‘what’, ‘when’ and ‘where’ related questions but solely permits for a limited understanding of participant’s views, thoughts and feelings (VanderStoep and Johnson, 2009; Glenn, 2010).

The key strength of qualitative research is that it allows for a deeper and richer understanding of phenomena and is particularly suited for exploratory-type enquiries and theory-development due to the iterative process of data collection and analysis (Sanders et al., 2014; Weiner et al., 2010). In particular, qualitative research allows for an investigation of ‘why’ and ‘how’ questions (Glenn, 2010). Yet, as O’Mahoney and Vincent (2014) highlight, the rejection of “any claims of (natural or social) science to provide ‘better’ understanding” (p.5) ignores the possibility of more accurate descriptions of reality. In addition, as qualitative research is based on a more focused, smaller sample, findings may not be generalisable to the larger population.

#### 4.4 Mixed-method research

Tashakkori and Creswell (2007, p. 4) define mixed methods as “research in which the investigator collects and analyses data, integrates the findings and draws inferences using both qualitative and quantitative approaches or methods in a single study”. It is increasingly being advocated to use mixed methods to provide a more rounded perspective on a phenomenon being examined, both in the healthcare and nursing literature (Williamson, 2005) as well as the broader HRM literature (Boselie et al., 2005; Sanders et al. 2014).

For example, Doyle et al. (2009) state that especially “healthcare researchers may benefit from the opportunity to use such a dynamic approach to address the complex and multi-faceted research problems often encountered in the health care sector” (p. 175). Within the field of HRM a mixed-method approach is advocated, particularly for HRM research which is more internationally focused (Batt and Banerjee, 2012; Kiessling and Harvey, 2005). This approach is in line with ‘critical realism’ which incorporates a “double recognition” (O’Mahoney and Vincent, 2014), meaning that it is acknowledged that there is an objective reality, but at the same time it is recognised that perceptions and experiences of this reality may vary due to subjective interpretations.

Indeed, this research benefits from adopting a mixed-method approach in several ways. Firstly, more generally, the rationale for using both qualitative and quantitative methods is that it allows to offset the limitations inherent in solely using quantitative or qualitative research methods respectively, namely through 'triangulation'. Thereby validity in the study's findings is increased. Overall, it enables a more comprehensive picture to be drawn about the way in which PA has been implemented and how it is being used and perceived in hospitals in different countries. It allows for stronger and more accurate inferences to be made regarding the role of wider contextual factors that shape the experiences of PA (Doyle et al, 2009; Greene et al., 1989; Bryman, 2006, Doyle et al., 2009; Sale et al., 2002).

An example of a study that has taken a similar approach conducted by Redman et al. (2000) looks at PA practice and incorporates both qualitative and quantitative research methods. This study focuses on a single-case study of an NHS trust and draws on interview, survey and documentary evidence. Redman et al. (2000) interviewed 7 senior managers and HR specialists and undertook in-depth, semi-structured interviews with 23 line managers and professionals drawn from a variety of backgrounds within the trust. This allowed them to explore the experiences of both appraisees and appraisers and to gain an understanding of the operation of PA (referred to here as individual performance review-IPR) and evaluate its effectiveness. The interviews were complemented by an analysis of internal documents (e.g. annual reports, training plans and strategies, procedure manuals) and three observations of training workshops on IPR and two senior management meetings reviewing IPR practice at the trust. Finally, a fully structured postal questionnaire was used to survey senior and middle managers and professionals about their experiences and views of being appraised and general attitudes towards appraisal. The quantitative part was particularly useful for illustrating certain elements of appraisal such as: what issues were covered in the appraisal and to what extent, perceived supervisor behaviour, questions regarding the extent to which appraisal is viewed as useful for setting objectives and feedback, and whether the way in which performance is measured had been agreed upon together with the supervisor and whether it is perceived as accurate. Overall, the use of mixed methods allowed the researcher to draw on various sources of evidence when discussing the findings and illustrate these in a more comprehensive way.

The value of a comparative case study approach is that it allows for an exploration of context variables and at the same time the identification of causation and generative mechanisms which explain potential variations or similarities in a process and/or outcomes. This is possible because of the in-depth analysis of specific cases and is further strengthened using multiple methods. Indeed, case studies often use several methods for gathering information through in-depth

fieldwork. The comparative, mixed-methods case study approach therefore allows to gain an in-depth understanding of the connections between the national context and nurses' experiences of PA whilst providing a more accurate basis for the identification of any causal mechanisms.

Three key decisions have to be made when selecting a particular mixed methods design (Creswell and Plano Clarke, 2007; Doyle et al., 2011). Firstly, there is the question of whether quantitative and qualitative research phases shall be conducted simultaneously or sequentially. Secondly, it is necessary to decide if both methods are of equal importance and thirdly, at what stage exactly mixing shall take place, e.g. at the interpretation or analysis phase.

In this study, an embedded design is used which means that one method is dominant while the other is used to support the results (Creswell and Plano Clark, 2007). Given the strengths of the qualitative approach and its relevance to the research questions, the qualitative research method is the principal one, followed by the quantitative part. More specifically, qualitative research is better suited to address questions concerned with 'why' and 'how' in this case in relation to nurses' PA in different countries.

Semi-structured interviews are the key method for data collection, and involve relatively open-ended questions (see below and appendix) designed to develop an unconstrained, broad understanding of the state of PA and the influences shaping it. Thereby, actor's perceptions and their lived experiences of PA as well as the context within which it has been implemented is the focus of attention. The qualitative data allows and is drawn on to explore the range of factors that influence the shape of PA at hospital-level and how nurses perceive and are affected by this practice.

The study by McGivern and Ferlie (2007) is a good example of where qualitative research methods, specifically semi-structured interviews, have been used to examine PA, in that case consultant (performance) appraisal (CA). In total, they conducted 66 semi-structured interviews. Most participants were consultants in two large NHS teaching hospital trusts (UK) but participants also included medical and clinical directors; hospital managers and professional associations. In their study, interviews served the purpose to explore "experiences of CA, the wider context in which it was situated and initial theoretical perspectives, (...), but allowed interesting new topics to emerge" (p.1370). Thus, qualitative interviews helped not only to explore experiences of CA (which could be categorised under 'developmental', 'disappointed reflection', 'defensive assessment' and 'cynical dismissal of CA as a waste of time') but also enabled the researcher to take the wider context into account and unanticipated themes to emerge.

Therefore, given the interest in how [national-level] contextual variables have shaped the nature and form PA takes, qualitative research methods, and specifically semi-structured interviews, are particularly appropriate as it allows for an exploration and a deeper, more rounded understanding of the phenomena (PA) within its wider context. In addition, unanticipated factors might be identified to matter. As Weiner et al. (2011) state, benefits which can be yield from qualitative research include “more in-depth, textured descriptions of what actually happens in practice settings (....)” (p. 5). Therefore, qualitative research is integral for this research to be able to explore rather than just test and moreover to include a range of perspectives, as further elaborated below.

#### 4.4.1 Incorporating a questionnaire: aim and rationale

While the general benefits of using a mixed-method approach in this study has been detailed above, and the rationale for using qualitative interviews as the dominant method has been explained, there are compelling reasons to make use of quantitative methods as well. Indeed, there are several studies that have taken a similar approach and combined methods effectively.

One such study is Truss (2001) who also adopts a mixed-method, but longitudinal, single case-study research design to examine what HRM practices and policies are implemented in a financially successful company and how they are enacted within the organisation. The qualitative part of the study asked more open-ended questions which meant that the researcher was “more open to the evidence of practice obtained from the organisation” (p1128) and enabled her to explore the perspectives and experiences of employees. The quantitative part served the purpose of then measuring perceptions of the formal HRM environment and its relationship with financial outcomes. This methodology allowed the researcher to show how a discrepancy between intention and practice of HRM practices occurs more effectively.

Finally, Townsend et al.’s (2011) study in four case study organisations in the construction industry in Australia explored a ‘working time intervention’ within each case using a mix-method approach where the qualitative part was dominant. A range of methods were adopted: questionnaire, long interviews, short episodic interviews, focus groups and a diary study. The long semi-structured interviews were designed in such a way that allowed for a better understanding of working time preferences of employees and various perceptions on the issue of work-life balance. Questionnaires gathered demographic data and used previously published and validated measures such as: supervisory and organisational support, organisational expectations of long work hours, work to non-work conflict and non-work to work conflict.



Bainbridge and Lee (2014, p. 25) distinguish between four general and overarching purposes of mixing methods, namely: i) *development*, ii) *complementarity*, iii) *expansion*, and iv) *triangulation*. Regarding the *development* purpose the key reason for mixing methods is to use the findings gathered with one method to inform the development of the following study. Here the focus is usually on constructing measures to be used in the subsequent part of the research. The *complementarity* purpose for mixed methods refers to the goal of “clarifying, enhancing, or illustrating the results from one method with the results from the other (...) so that strengths of one compensate for the weaknesses of the other”. Mixed method research with an orientation towards *expansion* seeks “an improved, more rounded understanding by utilising different methods that have unique strengths in revealing different characteristics of a phenomenon”. Lastly, the purpose of *triangulation* implies the goal to “examine the same phenomenon to assess the degree of convergence in the findings and corroborate the results of one study through the findings of another”. Here, similar data can be collated from different respondents, for example. If similar findings emerge, conclusions can be made with greater confidence and although findings may vary, this can indicate different perspectives and contribute towards the breath and richness of the study. However, these different purposes are not mutually exclusive. This study certainly seeks to benefit, first of all, from both the strengths of qualitative and quantitative research methods (complementary). As in the case study by Redman et al. (2000) mentioned above, the quantitative part is particularly useful for illustrating the results together with the results gathered through interviews. However, in addition to complementarity, this study seeks an element of both expansion and triangulation. On the one hand, a more rounded understanding of the influence of country context on nurses’ PA is sought (expansion) while using both methods to assess the same phenomenon to ensure greater confidence in the finding’s results (triangulation).

Overall the questionnaire in this study covers similar issues as those covered in the interviews. Thereby, the results of the quantitative phase serve to support and complement the findings of the interview phase. More precisely, in the UK a national staff survey is conducted each year across the NHS which also covers relevant questions on appraisal and associated issues (see appendix 3). Given the availability of this survey, it was deemed useful to replicate these questions in surveys distributed in the German and Czech hospitals under investigation.

#### 4.4.2 Sample

Collins et al. (2006) distinguish between different mixed methods designs not only in terms of whether qualitative and quantitative components occur sequentially or concurrently but also

regarding the relationship of qualitative and quantitative samples (identical vs. parallel vs. nested vs. multilevel). Identical means that in each research phase exactly the same sample members participate in the study, parallel means that samples from both study components are different albeit from the same population, nested means that sample members from one phase of a study are a subset of those sample participants from the other part of the research and multilevel means two or more sets of samples are drawn from different populations. In relation to the quantitative phase, general nursing staff was surveyed as this is the occupational group of interest in this research. Questionnaires were distributed in the hospitals in which fieldwork was conducted in each country (see below). As such, the relationship of qualitative and quantitative samples can be described as 'nested' because the sample members from phase one are a subset of those from part two. The relevant parts of the NHS staff survey were replicated, i.e. those questions related to PA were used for the survey.

The reason for incorporating two hospitals specifically in the German case is that Germany's federalist nature was anticipated to make Germany a more complex case to study. For example, there might have been variations according to the federal state which needed to be considered. Thirdly, Germany has a diversity in terms of hospital ownerships (e.g. public-sector hospitals can be Ltd. organisations) which might have been relevant regarding the use of PA which had to be taken into account by including two different types of public-sector hospitals in Germany. Germany provided opportunities for very good access. The number of hospital cases was matched in the Czech Republic. Overall, an incorporation of two hospitals in two countries contributes to the 'depth' of the research findings and, as highlighted, above allows to control for the sector.

Nurses as an occupational group were chosen because they are the largest occupational group in healthcare. Nursing is a particularly interesting occupation to investigate since "nursing as a profession is always evolving" (Marrelli, 2006, p. 19). Whilst a number of specialist roles have developed within nursing, this study concentrates on *general* nurses as most nurses remain in generalist roles and because they comprise the largest segment of the workforce. Across countries, general nurses have relatively similar roles and job-descriptions and can be suggested to have reached similar degrees of professionalisation, which may have implications for PA.

The hospital sector was chosen as it represents a large part of the public sector. Public sector hospitals were deliberately chosen for three reasons. Firstly, as mentioned above, by focusing on public sector hospitals, the hospital cases are sufficiently similar in terms of sectoral characteristics which ensures a comparison of 'like with like' and thus enables a more thorough comparison of PA in different national contexts and allows for stronger inferences to be made.

Results in private sector hospitals may have differed in comparison to public hospitals due to different philosophies and management models, but the focus is on country differences rather than sectoral differences. Secondly, the focus is on the public sector because, as established in chapter 2, PA research tends to focus on the private sector and thus there is a need for more research on the public sector. Thirdly, in the public sector is particularly relevant in relation to NPM, an PA is an important dimension of NPM, however a rather neglected area in the NPM debate.

The organisational structure of public sector hospitals can be argued to be very similar, representing the 'professional bureaucracy' as defined by Mintzberg (1992). Professional bureaucracy implies that the nature of work in these large organisations is such that highly trained professionals are granted high levels of autonomy regarding their own work. Moreover, the labour-intensive nature of hospitals makes the effective use of and approach to HR crucial (Kabene et al., 2006). As Townsend and Wilkinson (2010, p. 332) highlight, internationally hospitals face similar and increasing pressures for efficiency and quality and indeed, "increasing pressures are being felt at hospitals (...) worldwide". As the demands of the sector are such that "there will be continuing pressure to achieve efficiency and other performance targets (...) and these will feed through to managers and staff" (p. 336), this research looks more closely at the HR practice of PA to see whether these common pressures have led to similar or different experiences of PA for nurses across the two countries. Effective PA for nurses in the hospital context is crucial, given the potentially positive outcomes for nurses themselves, such as reduced stress (Wright, 2014) as well as for patients via improved patient care and reductions in patient mortality (West et al., 2002).

In summary, a mixed method approach in the form of a comparative case study addresses the specific issues raised in this study more fully. A comparative case study design that uses multiple methods is the most suitable approach, as it allows for an in-depth exploration and an investigation of wider contextual influences as well as wider generative patterns which explain potential variations or similarities between countries in terms of PA. Whilst quantitative research is better suited for establishing causal relationship and generalising its findings, it largely ignores broader contexts and fails to explain the 'how and 'why' questions more fully. Given that the questions of 'why' and 'how' of nurses' PA are central to this study, the qualitative component of the study is the dominant one. Indeed, qualitative research benefits from a more in-depth understanding of the processes under investigation and allows for contextual factors to be explored more comprehensively. The quantitative element of the study takes an important complementary role, allowing for stronger conclusions to be made, and to verify causal

relationships uncovered by the qualitative phase. Overall, the use of multiple methods increases the finding's validity, comprehensiveness and allows for more accurate inferences to be made.

#### 4.5 Data collection: Research question & methods at each level

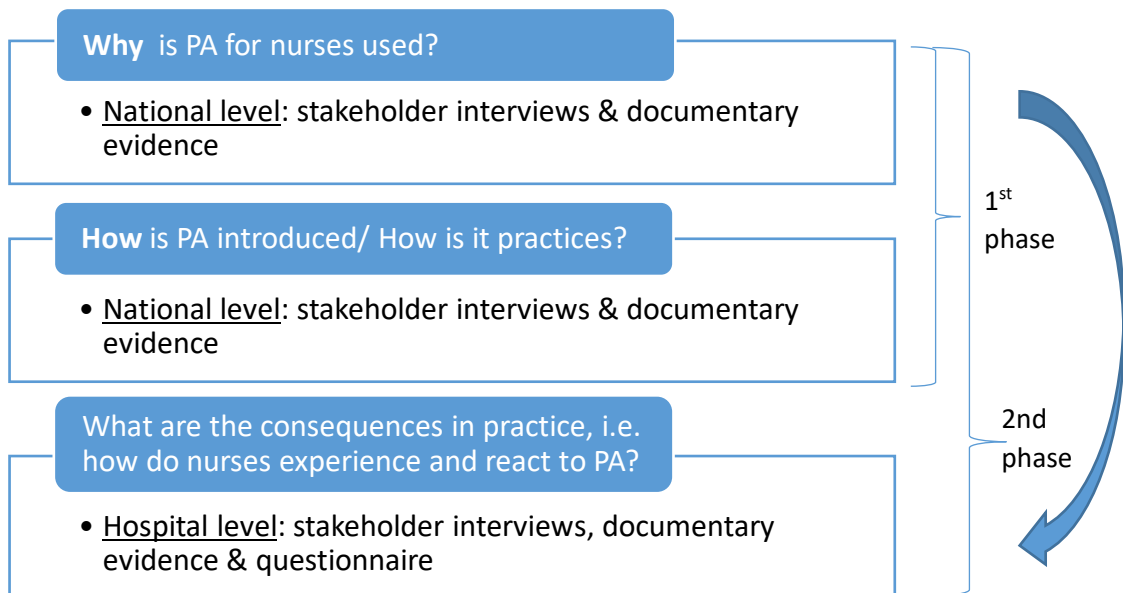
##### 4.5.1 1<sup>st</sup> phase: National level stakeholder interviews

*Research Question: Why is PA used for nurses in hospitals (in Germany and Czech Republic) and how is it practiced?*

*National-level semi-structured interviews (+ publicly available and given documents)*

As illustrated in Figure 4.2, in the first stage of the qualitative phase, broader national-level semi-structured interviews were conducted in each country with individuals from: relevant trade unions, professional associations, nursing directors/managers from various hospitals, and other relevant healthcare or nursing-related or employer organisations. These interviews usually lasted for one or more hours and followed the broad guide provided in appendix 8. This was complemented by documentary collection of reports, collective bargaining agreements and other documents either publicly available or provided by interview participants. This stage of the research is important for several reasons.

**Figure 4.2: Research question & methods at each level**



Firstly, it is particularly important to understand the meaning ‘performance appraisal’ has for the participants in the study, since the concept and the understanding of what it constitutes may differ across countries. As Hantrais (1999, p. 104) suggests “the question of the equivalence of concepts in different contexts has become a central issue in cross-national comparisons” which

therefore had to be considered via the qualitative part of the study. Secondly, these interviews provided a basis for a better understanding of the context for nurses more generally in each country and for the hospitals in which they work. Particular themes of interest and questions asked were concerned with: general pressures facing hospitals in the country and the general situation for and status of nurses, as well as the significance of performance management and appraisal more generally in the hospital sector. It was furthermore important to incorporate several information sources, including publicly available information and sources provided by interviewees (for example PA forms, collective agreements), but also perspectives from management, nursing directors, professional associations, trade unions and others to determine, for example, the legal and regulatory context of PA. The use of semi-structured interviews allowed for the possibility of identifying other, unanticipated influencing factors stemming from the wider context that relate to PA. Thirdly, initial national-level interviews provided preliminary findings in relation to the research questions posed and allowed for an estimation to be made in terms of the relevance of PA and what system is being used to appraise general nurses in hospitals. These interviews also provided information about who the typical decision-makers are regarding PA implementation, the nature of PA and how it usually translates into practice. Finally, this research stage proved crucial for the identification of hospitals in which to conduct further in-depth fieldwork. The combination of broader national-level interviews in combination with detailed fieldwork in individual hospitals allowed for both a contextualised and in-depth understanding and for connections to be made between national level influences that shape nurses' PA in the hospital sector in each country.

#### *German national stakeholder interviews*

Most national stakeholder interviews took place between September 2014 and September 2015 and were recorded after consent was sought. Interviews were semi-structured in nature (see appendix 8 for interview guide), lasted approximately an hour, and questions revolved around: the current hospital landscape and pressures, the status of nursing and the general use of PA. In total, eleven national-level interviews were conducted with relevant stakeholders based in various cities and federal states, five of which were telephone interviews. Interview participants included: one representative from the main nursing association in Germany (DBfK); three nursing directors (of which 2 university hospitals; 1 charity hospital) who are also engaged in other organisations (e.g. association of nursing directors etc); one representative from the German Hospital Institute; one union secretary from the trade union ver.di; one representative from the German Network for Quality Development in Nursing; two HR-managers (church hospitals); one works council representative (municipal hospital); and one representative from

the Hospital Association NRW. In addition, an informal, i.e. unrecorded conversation took place with someone from the German Accreditation Body.

<b>Table 4.1: National stakeholder interviews in Germany</b>	
Interview 1	The German Nurses Association (DBfK); Federal Association Nursing management; former nursing director
Interview 2	Nursing director 1 (foundation hospital); board member German Society for Quality Management in Healthcare
Interview 3	Nursing director 2 (university hospital 1); chairman of Association of university hospital nursing directors
Interview 4	German Hospital Institute
Interview 5	Trade union secretary Ver.di 'united services union'
Interview 6	German Network for Quality Development
Interview 7	HR manager (Education) church hospital
Interview 8	HR manager (Personnel) church hospital
Interview 9	Works council representative (municipal/public sector hospital)
Interview 10	Nursing director 3 (university hospital 2)
Interview 11	Hospital Association North-Rhine Westphalia (KGNW) (with nursing background)
Conversation 12	German Accreditation Body

#### *Czech national stakeholder interviews*

The majority of national stakeholder interviews took place between March 2015 and April 2016 and also lasted a minimum of 1 hour and followed the same set of questions as in the German case. In total, nine national-level interviews were conducted with relevant stakeholders based in various cities, four of which were telephone interviews. Interview participants included: The Director of the HealthCare Institute, one representative from the main nursing association; one chairman of the major Czech hospital accreditation body; one representative of the professional and trade union for healthcare workers; and higher managing nursing staff of different hospitals in the country, including one Deputy Director of nursing care and quality and two head nurses of major departments.

<b>Table 4.2: National stakeholder interviews in the Czech Republic</b>	
Interview 1	Czech Nursing Association (Member of the Executive Board)
Interview 2	HealthCare Institute (Director)
Interview 3	President of the Czech Association of Nurses (CAS)+ Deputy Director of nursing care and quality at a hospital in Prague
Interview 4	President of Professional and trade union for healthcare workers (Profesní a odborová unie zdravotnických pracovníků)
Interview 5	"United Accreditation Commission" Spojená akreditační komise (SAK) Co-founder & Chairman of the Board of directors, auditor, consultant
Interview 6	Head Nurse at big hospital in Prague; Chairman of certain section at CAS
Interview 7	Head Nurse /Matron at big Hospital in Prague
Interview 8	Midwife (hospital in East Czech Republic)
Interview 9	Czech nurse with 5-year experience of working in the NHS (UK)

#### 4.5.2 2<sup>nd</sup> phase: Detailed fieldwork in hospitals: appraisal in action

##### *What are the consequences in practice, i.e. how is the process of PA experienced in hospitals?*

National-level stakeholder interviews were followed by detailed fieldwork in two hospitals in each country to assess whether the rationale for PA, and what PA is intended to achieve, is translated into practice. This involved both qualitative and quantitative research approaches.

Regarding the quantitative research phase, the questionnaire asked direct questions about PA and their consequences (e.g. “Did [PA] leave you feeling that your work is valued by your organisation?”) and more general questions about satisfaction levels in relation to workplace-level issues (such as “How satisfied are you with the recognition [you] get for good work”). Biographical data (e.g. gender, age) was also collected (see appendix 3). The usual procedure for handing out questionnaires at the hospitals was that the nursing managers took charge and distributed the questionnaires and information sheets across different wards to general nursing staff and collated the completed surveys using a sealed box with a slot. While all participating hospitals in this study allowed the distribution of questionnaires, at Hospital ‘Nordrhein-Westfalen’ it was only possible to distribute questionnaires and information sheets directly at those wards visited for interviews. Therefore, the number of completed questionnaires is significantly lower than in the other hospitals (German hospital case “Rheinland-Pfalz” n=99; Czech hospital case 1: n=200; Czech hospital case 2: n=175), amounting to just 26 completed questionnaires.

The qualitative research phase at hospital-level involved: firstly, semi-structured interviews with managers, nursing leaders, WC representatives, and general nurses (thereby incorporating both appraisals and appraisers) and secondly, collection of relevant documents provided by the hospitals (e.g. PA forms and guidelines, annual hospital reports, written agreements with WC etc.). This set of interviews allowed to address the research questions in relation to the consequences of PA at the hospital level in more detail. Moreover, the detailed processes associated with PA (‘how’) as well as the nature of PA could be examined in depth. Again, information provided in the interviews were corroborated with documents, particularly the respective appraisal forms but also information provided on the intranet (where available), HR guidelines, preparatory forms, additional documentation (such as booklets with explanations and examples provided for various evaluation scores to the appraisers) and works agreement between the works council and management (where it existed).

Interviews enabled the incorporation of general nurses’ own experiences of PA, including *their* attributions of the “why” (Nishii, Lepak and Schneider, 2006) of PA. It allowed the exploration

of: how nurses perceive the process, what outcomes it has for them and how they reacted to PA. Interviews, especially with the higher-level managerial staff, also covered questions regarding current hospital pressures, general trends and the status of nursing, as indicated in the interview guide (appendix 8). Results of the findings were then compared to the dimensions identified in Chapter 2 (table 2.4) and interpreted using the framework for comparison. The hospitals are illustrative of whether the PA systems at its implementation stage achieved what it is intended to in practice.

#### 4.5.3 German hospital cases: Background information

##### *Hospital “Rheinland-Pfalz”*

###### *Number of interviews:*

In total 22 interviews were conducted at the first German hospital, called “hospital Rheinland-Pfalz” (RP) for the purpose of this study, as it is located in the federal state ‘Rheinland-Pfalz’ (Rhineland-Palatinate). The hospitals and participants in this study are treated anonymously, so that those who participated cannot be linked to the particular wards or hospitals they are working for. The first two interviews at this hospital were conducted in September 2014 with the nursing director and a substitute ward manager, who is also a delegate of the German Nursing Association and involved in the establishment of Germany’s first nursing chamber. In August 2015, further interviews were conducted with: six ward managers (nurses), twelve general nurses, one WC representative, and one administrative staff. A range of wards have been visited during the course of interviewing, namely: Clinic for Oral and Maxillofacial and Plastic Surgery; surgical clinic; dermatology clinic; intensive care unit; emergency/A&E unit; Radiological Oncology; internal medical clinic; eye clinic.

###### *Background information:*

Hospital ‘Rheinland-Pfalz’ is a public hospital and in municipal ownership. Since 1995 it is organised as a non-profit limited liability company [gGmbH], which is also its legal form. This however does not affect its categorisation as a public-sector hospital (Rehborn and Thomae, 2008). The hospital has 939 beds, with 15 clinics, 5 medical institutes and 12 (competence) centres and in total 40 wards. It is also an academic teaching hospital. Since 2009, the hospital is certified by KTQ, one of the bigger certifiers in the healthcare sector. In 2014, the hospital employed 2,622 staff, of which 393 belong to the medical service (doctors), 1,354 to nursing and functional service and 875 ‘other’ staff. The Quality-report 2013, the most recent available, provides a more detailed overview of employment data. It suggests that in 2013 there were 690.8 FTE general nurses employed, alongside 6.9 FTE pediatric nurses, 6.4 FTE nurses for the elderly, 27.6 nursing assistants and 5.2 surgical assistants.



### *Hospital “NRW” (Nordrhein-Westfalen)*

#### *Number of interviews:*

The second German hospital is located in the federal state ‘Nordrhein-Westfalen’ (North Rhine-Westphalia), in short ‘NRW’, and entitled ‘Hospital NRW’ in this study to ensure anonymity. In total, 20 interviews were conducted here. Interviews were conducted in January 2015 with the managing director of the hospital, who is also a board member of the ‘German Hospital Association’, chairman of the expert committee Personnel/Organisation/Quality in Berlin, vice-president of Hospital Association North Rhine-Westphalia, chairman of hospital (special-purpose) association Cologne/Bonn and region and involved in negotiations for the Association of Local Government Employers (VKA). Subsequently, interviews were conducted in February 2015 with the deputy nursing director and in June 2015 with the chairman of the WC, and in April 2016 with: three divisional managers, five ward managers, seven general nurses, one healthcare assistant/educator, and one with the new deputy nursing director. Again, interview participants worked at a similar range of different wards: internal medicine; intensive care unit; ‘General surgery/ gynaecology/ neurology’ division; Child and Adolescent Psychiatric Services; A&E/ emergency department; paediatric clinic.

#### *Background information:*

Hospital ‘NRW’ is a public-sector hospital and in municipal ownership. Since 2008, the hospital ‘NRW GmbH’ forms the umbrella organisation for two district hospitals, a centre for mental health as well as a psychosomatic clinic and all of its subsidiaries. The hospital as a whole has 1037 beds (date: 10.12.2014). It employs 274,3 FTE physicians (medical service), and 794,9 FTE nurses (in addition to 40,1 FTE paediatric nurses and 6,5 FTE nursing assistants). In terms of quality management/ certification, the hospital’s website states that [translated]: “The quality management system of ambulatory, outpatient and inpatient care at the hospital is certified according to KTQ since 2003 and since 2014 according to the specifications of DIN EN ISO 9001:2008”. In addition, specific centres within the hospital have field-specific external certification, namely the breast centre, Intestine Centre, Head-Neck-Tumour Centre, the endoprosthetic centre, stroke unit, trauma centre and the ‘pain-free hospital’. Thus, the hospital engages in various processes of external quality assurance.

### *Hospital “Rheinland-Pfalz” vs. hospital NRW*

#### *Legal form*

According to the Federal Statistics Office (2015), in Germany it can be differentiated between three types of hospital ownership: public hospitals (usually owned by municipalities/local government), private (for-profit) hospitals and voluntary non-profit hospitals (often owned by churches or the German Red Cross). Furthermore, one can distinguish between private-legal and public-legal forms, which is not necessarily related to ownership. Public hospitals can either operate under a private-legal or public legal form. Public hospitals with a private-legal form can for example, as in the case of ‘hospital NRW’, be organised as a GmbH, i.e. a limited liability company. Likewise, public hospitals can be organised as a gGmbH, the non-profit variant, as is the case with ‘hospital Rheinland-Pfalz’, which implies that it is also organised as an enterprise but with a non-profit status (Greer et al, 2010). Changes to the legal form of hospitals has been a clear trend in Germany such that in 2014, 59.4% of all public hospitals in Germany were of private legal form (Federal Statistics Office, 2015; Glassner et al., 2015).

#### *Summary*

Both German hospital cases are public hospitals and can be classified as municipal/communal hospitals with a private legal form: hospital NRW is organised as a limited liability company (GmbH) and hospital ‘Rheinland-Pfalz’ as a non-profit GmbH (gGmbH). There might be some variations regarding co-determination rights between WC depending on whether the hospital operates under a public or private legal form (e.g. Jevtic, 2012). Since both hospitals operate under some variant of the private legal form, this aspect is therefore not a source for variation. Based on interviews conducted in Germany more generally, this aspect has also not been identified to be a significant issue in terms of the adoption of PA in German hospitals. In both cases, staff are covered under the TVöD-K (collective agreement for the public sector, hospitals) due to the employers’ affiliation with the Association of communal employers (VKA). Both are large hospitals (hospital Rheinland-Pfalz: 939 beds; hospital NRW: 1037 beds), with one being the second biggest hospital (in terms of beds) and the second largest employer within its federal state. Both hospitals engage in various external quality management certification processes. A similar number of interviews was conducted at various and similar wards.

#### 4.5.4 Czech hospital cases: Background information

##### *Hospital "South"*

###### *Number of interviews:*

In total 23 interviews were conducted at the Czech hospital called "hospital South" for the purpose of this study, as it is located in the South Moravian Region. Fieldwork took place in late August/September 2015. Interviews were conducted with participants of different levels of hierarchy, including: the managing director, the nursing director, seven ward managers (4) or divisional managers/matrons/head nurses (3); nine general nurses, four healthcare or nursing assistants, one WC representative. Those interviewed were associated with various wards including the surgical unit, the male and female inpatient department of internal medicine; internal medical clinic; gynaecology unit, intensive care, operating theatre, central sterilisation.

###### *Background information:*

Hospital 'South' is a public, district hospital, operating under public law. The hospital has 200 beds, with a range of wards, namely: Internal medicine ward; gastroenterology department; Surgical ward, Central operating rooms and central sterilization; gynaecological department; Children's department; Anaesthesiology and Resuscitation; Haemodialysis department and ambulance nephrologic; Department of Radiology; Department of Laboratory Medicine; rehabilitation department, Department of Tuberculosis and Respiratory Diseases, and an institutional pharmacy. In 2015, the hospital employed overall 498 staff, of which 238.8 (FTE) were nurses and 58.5 (FTE) were doctors. The Business-report for 2015 provides a more detailed overview of employment data. It also indicates that the hospital is engaged in various certification and accreditation processes. It states that the hospital has the following certificates: Quality management system certification in accordance with ISO 9001: 2009; Accreditation of Laboratory Medicine Department of ISO 15189: 2007; Certificate of verification of quality and safety of healthcare services; Certificate management system of social responsibility of organizations CSN 01 0391: 2013. In addition, the hospital was the winner and judged to be the best organisation with regard to 'social responsibility' within the category "Public sector - other organizations of more than 50 employees" in its region, and received a certificate entitled "Responsible organisation South Moravian Region 2015". Further, based on staff and patient ratings via surveys by the HealthCare Institute, the hospital was ranked at the 41<sup>st</sup> or 42<sup>nd</sup> place of 157 hospitals in the Czech Republic (according to interview).

### *Hospital “North”*

#### *Number of interviews:*

In total 21 interviews were conducted at “Hospital North”. It is based in the north part of the Czech Republic, approximately 64 km (40 mi) northwest of Prague. The first set of interviews were conducted in August 2015, with 11 participants, namely with the hospital’s nursing director and head nurses of various divisions. Further fieldwork took place in June 2016. Interviews took place, once again with the nursing director as well as with the “manager of the marketing department and of ‘internal audit and quality’” and moreover a newly appointed head nurse and 8 general nurses.

#### *Background information:*

Hospital “North” is a public ‘city’ hospital (i.e. municipal ownership, operating under public law). In 2015, the hospital employed 328.36 (FTE) general nurses and midwives, 101.20 doctors, amongst others (e.g. pharmacists; 63.16 FTE Non-medical health workers working without supervision; 154.71 FTE healthcare workers, working under professional supervision). The hospital has 560 beds, with a range of wards namely: Anaesthesiology and Resuscitation ward, Children’s/paediatric ward, Gynaecology-maternity; surgical ward; internal medicine; gastroenterology; Clinical Biochemistry; Clinical Microbiology; LDN (for long term sickness); Neurology; MOJIP (Multidisciplinary Intensive Care Unit); Operating rooms; Orthopaedics; ENT; polyclinic; radiology; Rehabilitation; Urology. In 2015, the hospital employed 101.20 (FTE) doctors and 328.36 nurses and midwives. Its annual report provides a more detailed overview of employment data. In comparison to hospital South, hospital North has no hospital accreditation but the legally required ISO certificates, according to Quality Management Standard ISO 9001:2008 (Provision of technical, operational, economic and business services of the hospital), specifically in the following areas: Pharmacy, Medical Supplies Shop; Department of Sterilization; Receiving Room; clinic of biochemistry and haematology [CSN EN ISO 15189:2013]; clinic of microbiology [CSN EN ISO 15189:2007]. In addition, in 2016 the hospital took part in the comparison of hospitals nationwide by the HealthCare Institute based on survey data completed by patients [outpatients and inpatients] and staff regarding their satisfaction levels and financial health of the hospital. Regarding employee satisfaction it achieved the 15<sup>th</sup> place, in term of the outpatient rating the 58<sup>th</sup> place and for hospitalised patients the 57<sup>th</sup> place.

### *Summary*

Both Czech hospital cases are public, non-profit hospitals and are either in municipal or district ownership. A similar number of interviews has been conducted in each of the two Czech and German hospitals across a range of different wards. In comparison to Germany, both Czech

hospitals are significantly smaller in terms of their number of beds and staffing. However, this is broadly representative of the respective country. According to Eurostat (2016) “among the EU Member States, Germany recorded not only the highest number of hospital beds (...) in 2013, but also the highest number relative to population size”. In addition, Germany’s population is approximately eight times larger than that of the Czech Republic (Germany: over 80 million; Czech Republic: approx. 10.5 million). Consequently, the typical size of hospitals differs across the two countries. The key difference between the two Czech hospitals relates to their engagement with external quality management certification processes, which affects the use of PA, as further discussed in Chapter 6. This choice of one hospital-wide accredited and one non-accredited hospital in the Czech Republic was deliberate because this emerged as the major distinction between hospitals in the national-level research phase and was therefore sought to be explored further at hospital-level.

**Table 4.3: Available beds in hospitals in the Czech Republic, Germany and EU**

<i>Per hundred thousand inhabitants</i>	<b>2014</b>
EU (28 countries)	521.3
<b>Czech Republic</b>	645.5
<b>Germany</b>	822.8

Source: Eurostat, [http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare\\_resource\\_statistics\\_-\\_beds](http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_resource_statistics_-_beds)

**Table 4.4: Summary of hospital cases**

<b>Hospital pseudonym</b>	<b>Federal State/ Region</b>	<b>Type &amp; Ownership</b>	<b>Legal form</b>	<b>No. of beds</b>	<b>No. of general nurses</b>	<b>No. of inter-views</b>
Hospital “Rheinland-Pfalz”	Rheinland-Pfalz, DE	Public, municipal ownership, Teaching hospital	non-profit limited liability company [gmbH]	939	690.8 FTE	22 (99 survey responses)
Hospital “NRW”	Nordrhein-Westfalen (NRW), DE	Public, municipal ownership, Teaching hospital	limited liability company [GmbH]	1037	794,9 FTE	20 (26 survey responses)
Hospital “South”	South Moravian Region, CZ	Public, district/ municipal hospital	“public-benefit organisation” i.e. non-profit/public law	200	238,8 FTE	23 (200 survey responses)
Hospital “North”	north part of Czech Rep.; ca 40 miles from Prague, CZ	Public, municipal hospital	“public-benefit organisation” i.e. non-profit/public law	560	328,36 FTE (General nurses & midwives)	21 (175 survey responses)
						<b>Total: 86 interviews; 500 survey participants</b>

#### 4.5.5 Analysis

The analysis of the qualitative data required the transcription of the interviews conducted, which was done by the researcher in question and author of the thesis in the language of the original interview. Thematic analysis was used to analyse the qualitative data gathered in the interviews using NVivo. According to Braun and Clarke (2006) thematic analysis is an analytical tool in its own right and is one of those methods that “are essentially independent of theory and epistemology, and can be applied across a range of theoretical and epistemological approaches (...)” (p. 78). They define thematic analysis as “a method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail” (p. 79). The six-step approach to thematic analysis is depicted in the table below and was adopted to analyse semi-structured interviews of this study. Both an inductive and deductive approach was used. Fereday and Muir-Cochrane (2006) show how the technique of inductive and deductive thematic analysis can be combined and rigour can be demonstrated “using a hybrid approach to thematic analysis” (p. 81). The inductive component allows for themes to emerge direct from the data, while the deductive component implies a ‘piori’ template of codes. In other words, whilst certain themes were apparent before analysis, reflected in the research questions, through analysis of the transcripts allowed for additional themes to emerge.

**Table 4.5: Phases of thematic analysis**

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (level 2), generating a thematic ‘map’ of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Source: Braun and Clarke (2006, p. 87)

Quantitative data gathered through questionnaires in the Czech and German hospitals was inputted into SPSS. Subsequently, SPSS was used to explore the data and used to demonstrate the survey results effectively, such as through tables, graphs and charts, especially for the feedback which was provided to the individual hospitals. A series of Chi-square tests and

independent samples t-tests Tests were conducted to explore variation between the Czech and German hospital cases, reported in Chapter 7.

#### 4.5.6 Researcher's Comparative Advantages

Within comparative case studies pragmatic factors also play a role, which has to be acknowledged (Hantrias, 1999). As Kaufmann (2014) argues in comparison to other fields of research, comparative studies “requires the researcher to develop relatively greater expertise in country-specific business systems, cultural heritages, and employment laws and institutions [...] a researcher also has to develop foreign language skills in order to read primary and secondary source materials and conduct (...) interviews with managers and workers who often only speak the local language” (p. 5). In this case, I as the researcher was able to communicate in the national languages and have sufficient understanding of cultural aspects in these countries. Often comparative research relies on several researchers conducting research in different countries, but in this study only one researcher could conduct research in the countries in questions. This is a key advantage as this enabled me as the researcher to make constant comparisons between countries while e.g. conducting interviews. As I was previously involved in EU comparative research projects within public sector organisations as a research assistant, I was particularly suited to carry out this study, given my previous experience.

## 4.6 Conclusion

Fundamentally, this study is concerned with PA from a comparative perspective. It seeks to investigate the 'why', 'how' and consequences of nurses' PA in hospitals in the Czech Republic and Germany, and examine the way in which the wider context contributes to similarities or differences in terms of these dimensions of PA. To address the specific research questions posed, a comparative case study design has been identified as the most suitable one. A range of important considerations when adopting a comparative case study approach were reviewed. First, regarding the unit of analysis, in this study, it is primarily the country cases. Secondly, cases should be selected on the basis of appropriate theory. In this case, institutional theory provides a tentative and plausible account, particularly for differences that might be revealed by the case comparison. Relatedly, it was identified that the most different system design - or the 'selecting for difference' approach - is the one suited for this study given the expectation that national differences will result in PA variation.

To identify the most suitable research methods, key paradigms were discussed and their key strengths and weaknesses identified. Thereafter, the main advantages of using a mixed method approach was highlighted. Overall, a mixed methods approach enables one to get different perspectives from the data and to provide a bigger picture which enhances the rigour of research (Williamson, 2005), from which this study also benefits. In relation to the specific approach of mixing methods, this chapter discussed several issues. Firstly, the priority in this study is given to qualitative research methods. This entails semi-structured interviews firstly, with 'national level' stakeholders and secondly, detailed fieldwork at hospital-level. This approach is particularly suited to answer the questions of the 'why' and the 'how' of PA and allows for an exploration of influencing contextual factors that have shaped PA in the different countries. Additionally, this study incorporates quantitative research methods with a questionnaire, distributed amongst general nursing staff at the participating hospitals. This questionnaire constitutes a replication of relevant parts of the British NHS staff survey and its primary role is to complement and triangulate the findings gathered in the qualitative phase. Overall, the combination of adopting a comparative case study design and mixed method approach allows for a thorough examination of the similarities and differences between countries in terms of the 'why', 'how' and consequences of PA and the identification of influencing factors stemming from the national context.



## Chapter 5: Findings: Germany

### 5. Introduction

This chapter presents the German case study findings. Section 5.1, explores the wider national institutional context and hospital environment in Germany, drawing primarily on ‘national-level’ but also workplace-level interviews, linked to the debates of previous chapters. It begins by exploring the broader pressures hospitals are confronted with in terms of efficiency and quality. By doing so, it also considers the role of quality assurance systems. Thereafter, it concentrates on the role of employment relations institutions including collective bargaining arrangements and employee voice mechanisms. Lastly, it explores the current state of nursing by assessing its general status, professional organisations and education system as this indicates the level of professionalisation reached. The connection between the national context and PA is flagged up and further explored in subsequent sections.

Section 5.2 introduces the main types of PA in the German hospital sector and their prevalence more broadly. It distinguishes between three broad variants of PA and identifies the dominant approach to PA for general nurses in the German public-sector hospital context.

Section 5.3 onwards focuses on the detailed examination of PA at two German hospitals. Extensive fieldwork was conducted in each hospital to identify 1.) the purpose of PA 2.) what form PA takes, and 3.) the consequences of PA. The overarching research question, namely whether, which and how national institutional factors impact PA approaches or whether organisational-level pressures override their influence is also addressed. Each hospital case will be presented using interview, documentary and survey data and available statistics.

## 5.1 Hospital & national institutional context: Germany

### 5.1.1 Overall hospital context & pressures

#### *Pressures for efficiency: privatisation, competition, financing and nursing shortages*

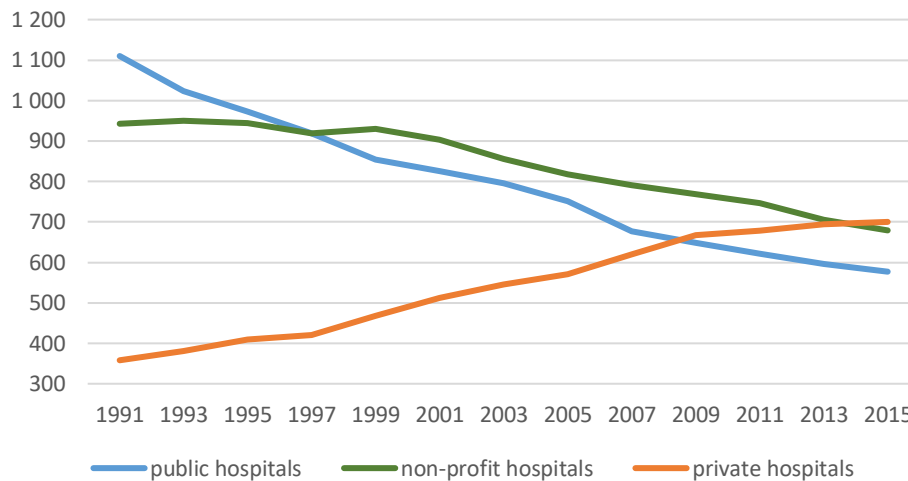
Interviewees confirmed the widely reported dual pressures of performing efficiently in a financially difficult context and pressures for quality. In terms of efficiency, it is widely reported that Germany has experienced unprecedented scales of hospital privatisation in recent decades (Böhlke et al., 2011) which was highlighted and identified as a threat for public-sector hospitals and by extension healthcare staff because privatisation is associated with less favourable employment conditions and a more demanding work environment by both interviewees and the literature (e.g. Schulten et al., 2008). There was a consensus amongst interviewees that competition between hospitals has increased in the face of this general trend of privatisations as well as hospital closures. Schulten (2006) identifies two main privatisation waves in the German hospital sector, the first after Germany's unification in 1990 and the second since the beginning of the new millennium which can be argued to have continued up to now (Glassner et al., 2015; Klenk and Reiter, 2016; Böhlke et al., 2011). This is in accordance with interviewees who brought cost pressures for hospitals firstly into connection with historical developments, mainly the reunification of Germany, which implied a need to invest in and up-date hospitals in the East, and the fact that historically there are a large number of hospitals which is deemed unsustainable. Therefore, it was argued, a large proportion of hospitals have been privatised and closures or mergers have occurred.

*This has of course also historical dimensions. We've witnessed in 1991 the reunification...we then of course had very major investment needs...especially in the East. And...we of course closed some hospitals, but not only in the East. (Deputy nursing director 1, Hospital NRW)*

This is in line with data by the Federal Statistical Office which suggests that between 1991 and 2015 there was a steady decrease in the number of hospitals, with an overall reduction of 19 percent (Statistisches Bundesamt, 2016). It can be differentiated between three types of ownership in the German hospital sector: firstly, public sector hospitals (owned either by the municipalities, regional districts or the German federal states), secondly, non-profit hospitals (usually run by churches or the German Red Cross), and finally private for-profit hospitals. In terms of the number of hospitals by ownership, data indicates that in Germany the number of public hospitals has decreased drastically and continuously which contributes to the reported competition between hospitals. As Figure 5.1 illustrates, between 1991 and 2015 the number of hospitals in public ownership has decreased significantly by 48 percent. The number of non-profit hospitals has also decreased albeit to a lesser extent with a reduction of 28 percent during

the same period, while the amount of hospitals in private ownership has increased substantially and almost doubled. Thus, it is primarily public hospitals, typically owned by municipalities, which have borne the brunt (Glassner et al., 2015).

**Figure 5.1: Hospitals by ownership in Germany 1991-2015**



Source: Statistisches Bundesamt (2016)

According to Glassner et al. (2015) as well as Böhlke et al. (2011) the push for the (second) privatisation wave in Germany is associated with political decisions in relation to changes in the refinancing arrangements for hospitals. In particular, the cap on hospital budgets, the abolition of the cost-containment principle and the introduction of the DRG (Diagnostic Related Group) system have led to high cost-competition and financing problems at many public hospitals (Glassner et al., 2015; Papouschek and Böhlke, 2008; Grimshaw et al., 2007). Specifically, the introduction of the DRG system in 2004 is argued to have put additional pressure on hospitals to increase efficiency (Mathauer and Wittenbecher, 2013). As highlighted in chapter 3, the introduction of DRGs has implied that hospitals would no longer be paid (by health insurance companies) on the basis of the length of the patient's hospital stay but instead on the basis of flat-rate payments. This means that there are now maximum (and minimum) number of days a patient can stay at the hospital depending on the degree of severity of the case, thereby increasing cost-pressures on hospitals and leading to a further overall reduction in the length of hospital stays (DPR, 2014). In fact, Klenk and Reiter (2016) argue that privatisation in the German hospital context was solely a "by-product" of such developments like those related to the introduction of DRGs which "forced hospital managers to manage and rationalise" (p. 270). According to Böhlke et al. (2011) the introduction of the DRG system in the German hospital

context has raised the scope to generate significant profits which has made them more interesting for the private sector.

This was confirmed by a range of interviewees who pointed to the DRG introduction as a key driver for having to increase efficiency, as indicated by the quotes below, and who suggested that even public hospitals are now operating like “economic enterprises”. Interviewees identified that hospitals, regardless of ownership, compete and have to “fight” to avoid potential future closures or, in the case of public hospitals privatisation, given the financial pressures (Glassner et al., 2015; Busse and Blümel, 2014). Overall, this has also implications for nursing in terms of the number of nurses employed and also e.g. work intensity.

*we're now more like economic enterprises than care facilities...hospitals are under ever increasing economic pressure also due to the introduction of DRGs and threats of hospital closures, every hospital is trying to make as little of a loss as possible or more profit (ward manager, Hospital RP)*

*Hospitals are all under tremendous economic pressure...with introduction of the DRG system, the entire hospital funding has indeed changed, and since then many nursing jobs have been cut...nurses must, in much faster time, take care of a lot more patients with less staff (Nursing director, charity hospital)*

*It has become very difficult in the hospital landscape and also a communal hospital like this one has to fight (WC representative, Hospital NRW)*

As indicated in the quotes above, it is argued that in the process of hospital mergers and/or closures nursing posts have also been adversely affected. According to ‘Der Deutsche Pflegerat’ (DPR, 2014) between 1995 and 2008 the number of full time nursing staff decreased by 14.2 % in general hospitals in Germany. Although since 2008 the level of employment within nursing has slightly increased in general hospitals, the overall reduction of nursing staff is still significant (e.g. 1995-2012: -11.44% [FTE]). Relatedly, the general shortage of qualified nursing staff was frequently highlighted by interview participants which is partly attributed to demographic changes, i.e. low birth-rates and thus a generally shrinking workforce. Furthermore, the lacking attractiveness of the nursing occupation and its overall status (or lack thereof) is argued to be the cause for this development. The prognosis regarding skills shortages is such that hospitals are expecting continuing recruitment difficulties in nursing.

*we're sliding into a nursing crisis...The problem is that nursing doesn't present itself as an attractive apprenticed occupation (Nursing director, hospital RP)*

*if we don't urgently...enthuse young people for the job...we'll look dumbfounded in Germany in a few years (hospital association North-Rhine Westphalia)*

Furthermore, it was reported that new recruits often leave the profession early due to working conditions at the wards. These working conditions are largely associated with pressures

stemming from privatisation threats and changes to the funding principle (DRGs) which in turn has implied a reduction in the length of hospital stay of almost 50 percent (Böhlke et al., 2011) and an increased throughput of patients. Also, demographic developments imply increased demand and a surge in the number of patients with more complex health issues which require more complex treatments, as indicated by the interview quotes below. Increased workloads are further exacerbated by the general nursing shortages.

*we have clear significant staff reductions within nursing...an increased number of cases and a reduced length of stay...all hospitals are under enormous cost pressure* (German Network for Quality Development in Nursing)

*...the care of patients in hospitals has become much more complex...the throughput of patients has changed enormously...Fewer jobs, and a significantly higher work effort due to the complexity.* (Deputy Nursing Director 1, Hospital NRW)

This is in line with research which confirms that the situation is such that nurses in Germany experience a high workload, often unattractive working conditions and a lack of prospects within the nursing profession, which is why a growing number of nurses are expected to leave the profession in the future (Hasselhorn et al., 2005; Rogalski et al., 2012). Nurses' workload and staffing levels are regarded as untenable. The "untenable situation in hospitals" is also evident in reports in the media, as one interviewee suggested, indicating the "*overstretching and burdening of staff and deaths due to the workload*" (trade union secretary).

As will be shown in the discussion of the German hospital cases, this wider hospital context is relevant for PA in different ways. Firstly, more broadly, some interviewees acknowledge that the subject of personnel management has generally increased in importance over the last decade or so, and with it also the role of PA. Thus, these wider developments in the hospital sector and emphasis on efficiency coincides with a greater concern for individual performance.

*...this field of personal development in healthcare has significantly gained in importance in recent years, as well as topics such as: staff discussions, staff guidance, leadership, have gained a totally different value* (Hospital Association NRW)

Secondly, these general pressures for efficiency and trends of privatisation or fears of hospital closure has the potential to influence the dynamic between the WC and hospital management which in turn may have implications for PA. Thirdly, the consideration of these general hospital pressures already indicates that nursing in Germany is experiencing a lack of prestige and recognition because not only have nursing posts been reduced radically over the last decades but many of those training places and nursing posts available cannot be filled due to a lack of nursing students willing to enter the occupation. This in turn can influence the way in which PA is adopted, as further explored in the following sections.

### *Pressures for quality: Quality management systems*

Alongside economic pressures on German hospitals, it was reported that demand for quality assurance has steadily risen as well. This is in accordance with the literature, which suggests that concern for quality management and assurance has risen across Europe, including in Germany (e.g. Breckenkamp et al., 2007; Busse, 2008; Wagner et al., 2014; Pross et al., 2017), and the interviews conducted.

*...immense economic pressure ... but the demands for quality are identical... partly also higher. The pressure is immense. (Nursing director, Hospital case RP)*

According to interviewees, there is a longer-standing legal requirement for hospitals to have 'quality management systems' in place, which implies that they must work according to so-called expert standards. While there is generally no requirement for these systems to be externally assured in the form of accreditation or certification, except for certain specialist areas, many hospitals undergo such processes on a voluntary basis. The main stated benefits for doing so relates to the issue of liability. It was also mentioned that there are plans by the German government (white paper on hospital reform, 2014) to link quality (management) to certain extra payments or reductions in the future.

According to an unrecorded interview, there are different norms and bases for external quality certification, with the two most relevant ones in the hospital sector being ISO norms (ISO 9001 - general norm & ISO 15/224 – for healthcare organisations), the most commonly used 'certification standards' in German hospitals, and KTQ (Kooperation für Transparenz und Qualität im Gesundheitswesen: cooperation for transparency and quality in healthcare), and the main accreditation organisation in the hospital sector which is specific for Germany and has its own system and requirements. This corresponds with the literature (Lindlbauer et al., 2016).

There are also many different certifiers in different fields of speciality, with their own systems and norms. Additionally, rules around certification can vary across federal states. Whilst quality management has been an important theme in Germany for some time, it has generally not been linked to PA. It was suggested that regarding ISO (15/224) there is a requirement that managers have to *somehow* assess staff in the sense of ensuring that staff are competent and qualified enough. The norm does however not specify that PA has to be conducted, instead norms are always kept relatively general. Also within KTQ the norm 'staff orientation' is kept relatively broad and vague and as such can encompass various things. It was emphasised that certifications can certainly happen without having PA in place and indeed this is often the case as WCs frequently resist the introduction of PA.

Most interviewees did not refer to “accreditation” or “certification” when discussing the introduction of PA and, when questioned, were clear in their assertion that PA and quality management/assurance are separate processes. For example, no direct link between certification and staff appraisal was reported by the interviewee from the German hospital institute, who stated that although ‘staff orientation’ is one of many points within quality management “*notwithstanding the topic ‘performance appraisal’ does not play an important role*”. The only potential link suggested was that within the scope of PA, goals can be formulated that aid the general processes involved during e.g. re-certification, or these goals can be more effectively communicated to staff which eventually aids the process – rather than PA being a necessary requirement for certification or accreditation. As such, while PA can potentially be used to prepare staff for external audits, this link was suggested to be only a very vague one and it was questioned whether it is achieved in practice. Overall, based on the interviews, it can be concluded that certification/accreditation is not the purpose of PA and generally no link between the two processes could be established.

#### 5.1.2 Employment Relations Institutions

##### *Collective bargaining agreement*

Within the “German dual system of representation” (Bosch et al., 2012, p.20), trade unions are responsible for concluding collective agreements and predominantly deal with issues relating to conditions of employment such as remuneration, while WCs, discussed in the next section, are in charge of those “formal working conditions” not regulated by the collective agreement (Baker and McKenzie, 2009, p.95). In many of the interviews conducted, participants referred to changes to the general collective bargaining agreement for the public sector, i.e. the move from the former wage agreement for all federal employees (BAT, i.e. Bundesangestelltentarifvertrag) to the new TVöD (wage agreement for the public service sector, i.e. Tarifvertrag für den öffentlichen Dienst) in 2005 within which the scope for performance-related bonuses (PRB) was included, applicable from 2007. The performance bonus component is primarily financed via the restructuring of the holiday and Christmas allowance which means that no additional funding is provided by the employer, and the employer is obliged to distribute the payment collectively (Meerkamp and Dannenberg, 2014; Schmidt et al., 2011).

*...as part of the transition from the old BAT to the TVöD...before, we had holiday pay, which has been withdrawn, the Christmas bonus has been lowered, and...the money that was saved, came into this performance bonus budget, roughly explained. And, in principle, it's money that people are entitled to anyway... (WC chairman, German hospital “NRW”)*

The actual collective agreement has several subcategories and is based on negotiations between the German Ministry of the Interior and the Associations of communal (local government) employers and the main trade union ver.di, with bargaining rounds taking place every two years. Whilst for the PRB component a start volume of one percent (of the permanent monthly salary of the previous year) was agreed, originally a steady increase to up to eight percent was envisaged. This intention however has not yet materialised due to controversies surrounding the PRB element (Meerkamp and Dannenberg, 2014). In the area of the Association of communal employers an arbitration result in the bargaining round 2010 resulted in an increase of 0.25% each year up to 2% in 2013, however no additional increases have been agreed since. For employers/hospitals to be able to implement PRBs to those employees whose employment relationship is based on the TVöD-K (agreement for public sector-hospitals), the collective bargaining agreement sets out the pre-condition of a works agreement between the local WC and the hospital's management. If no such agreement is reached, the 'watering can' principle is applied whereby staff automatically receive these additional payments rather than being depended on performance.

Many interview partners elaborated on the difficulties surrounding the current TVöD. Although the amount of the PRB bonus is still judged as insignificant, the addition of this PRB option is seen as an important step from the employers' perspective and particularly relevant for the area of nursing since otherwise there is little pay differentiation in the TVöD with regard to e.g. qualification levels or managerial responsibilities (according to interview conducted with employer side, i.e. Hospital Association and Association of Local Government Employers [VKA]). However, it is acknowledged that the performance premium cannot rectify these issues altogether and therefore these remain current issues which are continuously negotiated.

Nevertheless, regarding the prevalence of PRBs for general nurses, there was a general agreement amongst interview participants that particularly in public hospitals the use of it is very rare. Instead, the so-called 'watering can' principle is usually applied. This implies that staff automatically receive additional payments rather than being depended on performance. This is in line with e.g. the trade unionist from ver.di interviewed who suggested that most hospitals waive this possibility due to the effort and costs associated with running such a system (e.g. time spent on individual evaluations). In other cases, it is the WC who would refuse to agree a works agreement on this issue, which is a precondition for its implementation. This was for example reported to be the case by one WC representative of a communal hospital. There, the employer wanted to introduce PRBs but this element was rejected by the WC. In addition, higher managerial staff such as nursing directors themselves often recognise the difficulties inherent in



such a system, including issues around how to measure performance. Therefore, hospital management's appetite to introduce PRB for nurses is often limited due to the perceived limitations and the effort-benefit ratio, alongside the difficulty of convincing WCs.

#### *Employee voice: works council (WC)*

An important institution in relation to HRM more generally emerged to be the WC which enables 'employee voice'. The role of the WC in Germany is enshrined by law in the Works Constitution Act. For the public sector, there are some specific regulations for WCs, or rather employee or staff councils as they are frequently referred to in this context. The rights of staff councils can vary slightly depending on the specific federal state (Bosch et al. 2012; Greer et al., 2010). However, overall staff or employee councils are equally regarded as strong and stable institutions that characterise the German system of industrial relations and the tradition of 'social partnership' (Hölscher and Whitaker, 2004; Holtgrewe and Doellgast, 2012; Giardini et al., 2005). This is in accordance with the interviews conducted, where it materialised that both WCs and/or staff councils have high levels of influence and are important stakeholders. Unlike trade unions, WCs are not allowed to initiate strikes, since the law envisages cooperative relations (according to the principle of 'trust-based cooperation') (Marburger Bund, 2013, p.34; Baker and McKenzie, 2009; Heywood and Jirjahn, 2014). Indeed, interviewees pointed to the strong embeddedness of the works and staff council's position within law, which stipulates that the employer and WC must cooperate on a basis of trust and meet and communicate on a regular basis.

WCs can be regarded as the "distributing centre between management and employee" (Giardini et al., 2005, p. 72-73), or intermediates who communicate with both management and staff regularly, and are thus an important employee voice mechanism (Sisson, 2010; Murray et al., 2013). Through the works/staff council employees can not only receive information on important issues but can also indirectly participate in decision-making processes (Giardini et al., 2005; Heywood and Jirjahn, 2014). Indeed, the literature often suggests that the "German model of co-deciding is unique" (Jevtic, 2012, p. 11; Hölscher and Whitaker, 2004). This is because WCs in Germany have extensive co-determination rights. Staff councils as well as WCs can, at the workplace level, negotiate 'works agreements' regarding issues which are within the scope of local-level decision-making. Once a works agreement has been concluded, it must then be uniformly applied to all employees.

Based on interviews conducted with WC representatives, there seems to be an awareness that WCs play an important and legally mandated role, while specifically nursing directors often

expressed frustrations regarding the extent to which works and staff councils can delay or even hinder processes and initiatives introduced by management. Given the strong legally embedded employee voice at workplace level through works/staff councils, it can be suggested that this compensates for the widely reported lack of united voice within nursing. One works councillor raised the view that nursing is not well organised at national level, and therefore the role of the WC is to counterbalance this by representing and “sensitising” staff at local level.

*We have a weak lobby, because nursing...still didn't manage to organise itself...we in the works council are trying to sensitise our colleagues, to reflect about oneself, that one is worth more... (WC chairman, German hospital “NRW”)*

Yet, it was emphasised that the works/staff council is neither solely comprised of nor solely representing nursing staff, but all occupational groups in the hospital. This, especially according to one nursing manager at a university hospital (nursing director 3), raises questions about the WC's effectiveness for generating benefits specifically for nurses. In other words, WCs operate under a more economic, trade union logic than necessarily a professional logic.

Nevertheless, works and staff councils can be identified as crucial stakeholders in relation to HR-related matters and indeed “probably the most influential labour market institution” (Giardini et al., 2005, p.68). Similarly, according to Heywood and Jirjahn (2014), WCs’ “rights are strongest in social and personnel matters, including the *introduction of payment methods (...)* allocation of working hours and the *introduction of devices designed to monitor employee performance*” (p.524-525). In fact, various authors refer to the co-determination rights of WCs in Germany which also relate to the implementation of HR-related practices, including PA (e.g. Kampkötter et al., 2017; Holtgrewe and Doellgast, 2012; Giardini et al., 2005; Festing and Barzantny, 2008).

Interviewees consistently highlighted that not only must the WC be consulted on issues like working hours, the recruitment of new staff and, importantly, management practices such as PA, but their approval must be sought before implementation. Thus, the WC limits unilateral actions from management (Heywood and Jirjahn, 2014) and structured PA systems must be approved by the WC and cannot be enforced. In addition to the ability to co-decide whether or not formal PA is implemented, WCs can also influence the content of PA (Giardini et al., 2005) and play an important part in overseeing the correct implementation of any agreed system (Heywood and Jirjahn, 2014).

During the German national stakeholder interview stage of this research, it already became apparent that whenever a formal system of PA for general nurses has been set up, this was only possible with the cooperation of the WC. In each case, the role of the WC in determining the precise format of PA was highlighted. In one instance, the works councillor of a communal

hospital (interview 9) reported that while the WC refused to conclude a works agreement on PRBs, they did agree to the use of so-called staff discussions, a form of PA. In addition, the WC was involved in the development of the general concept and co-decided the themes that would be covered in those discussions. Similarly, at a university hospital it was reported that the staff council was involved in the preparation of appraisal-related documents and even had to be consulted regarding minor changes to the wording of a certain section, as this required their authorisation (nursing director 3).

In many other interviews, it was stated that the introduction of PA can be, and indeed is often, hampered by works or staff councils due to their concerns in relation to the potential control effects of PA. Particularly in cases where no systematic and regular PAs are conducted for general nurses, the resistance by the WCs has been stated as the core reason for it. For example, one nursing director (nursing director 1) reported this to be the case at their hospital. As to the reason why this hospital does not have any kind of PA for general nurses, it was stated that the general stance of the WC contributed to this.

According to Kampkötter et al. (2017) there are indications that WCs tend to not be keen on implementing PA due to concerns about performance monitoring. Similarly, Giardini et al. (2005) suggest that WCs tend to resist the introduction of formal PA systems because of the potential of performance pressures, especially when linked to compensation. In many organisations therefore, including hospitals, only top-level management tend to be subjected to formal PA. Concurrently, it is suggested that precisely because the co-determination rights of work councils implies they must be consulted and their approval sought, this might actually facilitate the adoption of appraisal due to the prevalent “cooperative behaviour, and (...) consensus orientation” (Festing and Barzantny, 2008, p.214) that it leads to, and ultimately also aids the legitimacy of PA, making the practice more accepted within the workforce once it is adopted (Kampkötter et al., 2017; Heywood and Jirjahn, 2014; Heywood et al., 2016). In addition, Giardini et al. (2005, p.73) report that in general, increasingly more “innovative solutions” are sought at workplace levels in Germany and not just resistance towards such practices exists, given the wider pressures within the environment reported above (e.g. economic pressures).

Overall, this suggests that hospital WCs in Germany may respond in different ways to the initiation by the employer to introduce PA. This is in line with studies which suggest that employer-works council relations may vary between hospitals from cooperative to more adversarial (Greer et al., 2010; Jirjahn et al., 2011) in part depending on the particular employers’ and WCs’ attitudes. As such WCs strategies may vary (Kotthoff, 2013). WC’s reactions are also shaped by the broader context such as the economic context (Greer et al., 2010; Marsden,

2015). While a general tendency or preference can be detected in relation to PA across WCs, there may be some variation. In some cases, the emphasis is on blocking the more control and discipline-orientated approaches to PA whilst in other cases the WC engages with the precise format of PA to promote a more development-orientated approach. In any case however, the WC represents a key institutional mechanism in relation to PA, further explored in the hospital cases.

### 5.1.3 Nursing in Germany

#### *Nurses' status*

Dent (2003) states that the formal status of nursing in Germany is a rather “lowly one” (p 141-142). Nursing in Germany is still characterised as having only limited autonomous scope for action (Darmann-Finck and Friesacher, 2009), limited decision-making powers, a lack of recognition, low remuneration (Ognyanova and Busse, 2011) and still striving for emancipation from the ‘medical dominance’ (Di Luzio, 2008). Overall, the literature argues that nursing in Germany is progressing slowly in terms of professionalisation (Krampe, 2013).

These conclusions are in line with interviewees' comments. There was a strong tendency amongst interviewees to describe the status of nurses in critical terms. Many referred to the perceived low pay and the faulty perception that nursing mainly implies menial tasks which was suggested to contribute to the recruitment difficulties experienced. Furthermore, many expressed the view that nursing is not regarded as an independent profession and highlighted the imbalanced playing field, due to the medical profession being an academised profession and nursing not, making it more difficult for nursing to assert itself.

*So nursing is (regarded as a) lowly occupation, still. Or as ‘the doctor’s assistant’ (ward manager 2, hospital RP)*

It was also recognised that nursing has failed to organise itself effectively. This was often linked to the way in which nursing views itself, which in turn was linked to the historically religious legacy of nursing which is still attributed to today's view of nursing of being a religious order rather than a profession. This is furthermore reflected in the fact that even today, in Germany, not the job activity of nursing is legally protected, but rather the job title.

*this is also historical in Germany...even so, [nursing] has never been a profession..(trade union secretary ver.di)*

#### *Professional organisations/associations*

There was a general agreement amongst interviewees that nursing in Germany lacks a united voice which was linked to the existence of a high number of different (specialist) professional

associations related to nursing, who oftentimes pursue different priorities, interests and demands. Membership these associations is voluntary (Schrumpf et al., 2011). The most important associations, including the largest professional association representing nurses namely the DbfK (Deutscher Berufsverband für Pflegeberuf), are joint together under the same umbrella organisation, the German Nursing Council (Deutscher Pflegerat), whose legal rights however do not extend beyond consultation rights on nursing matters. As Dent (2002) notes the DbfK “has no legal role as a professional body” (p. 155). At a political level therefore, the position of nursing is still regarded as of limited influence (Kirpal, 2003). One interviewee (from the German Nurses Association, DBfK) specifically made a link between the position of professional associations, the lack of a united voice and the lack of professionalisation.

*we in nursing have never been able to be united..(German Nursing Association)*

*Nurses...aren't well organised...this is reflected at the political level, so they don't have to involve nursing in any decisions...they don't have a right to vote. (Hospital Association NRW)*

Moreover, all interviewees made some link between the, as yet, lack of nursing chambers, the status of nursing and nursing's lack of political clout. This was contrasted to the situation for physicians who have physician's chambers at the federal state level and the German Medical Association as the joint association and central organisation in the system of medical self-administration which represents physicians in policy issues and also “plays an active role in opinion-forming processes (...)” (Bundesaerztekammer, 2014). The individual chambers register and regulate practicing doctors but are also regarded as important for lobbying and a focal point for doctors' professional identity (Dent, 2003). An equivalent nursing chamber however does not exist in Germany. As according to Busse and Blümel (2014, p. 49) nursing associations “have correspondingly fewer financial resources and less political clout”.

Still, interviewees highlighted the positive development of the establishment of the first nursing chamber however only in one of Germany's federal states. However, progress regarding this has been slow. Many participants identified a lack of political awareness within nursing which is said to have hindered further progress across federal states. This is related to and evident in the fact that professional associations and trade unions are experiencing low membership levels, and general difficulties to mobilise nurses. The most important union in the hospital sector, ver.di, represents a range of occupational groups in the private and public sector. Its role lies mainly in the negotiation of collective bargaining agreements and key employment conditions. According to Grimshaw et al. (2007) union density generally tends to be well above average in public hospital sectors, but Germany is a notable exception as employees are “relatively weakly

organised” (p. 599). Despite ver.di’s important function, many interviewees argued that only a nursing chamber can bring the professionalisation of nursing forward.

Despite slow progress, the establishment of the first nursing chamber, the equivalent to the NMC in England, initiated and supported by professional associations, is seen as an important first step for nursing. The positive view of nursing chambers is generally held not only by professional associations but also nursing directors and ward managers interviewed who see it as a *“giant leap forward”* (e.g. nursing director 1) and many other interviewees regard it as an essential step in becoming an independent, self-regulating profession because it entails that nurses would fall under the so-called Heilberufsgesetz (law for public health profession/medical profession act) together with e.g. the medical profession, pharmacist etc.. This implies that nurses would be “equal partners”, governed by the same law, and therefore would have a voice on political boards (according to deputy member of the founding conference). The long-term expectation of supporters of the nursing chamber is that, in time, each federal state would have a nursing chamber and that then a federal nursing chamber could be set up which would have a seat in the joint national committee and that thereby the level of professionalisation and the overall influence of nursing can be increased. According to Kiefer (2014, p. 51) (translated) “nursing will finally be heard (...) The nursing chamber (...) will (...) for the first time provide a uniform and legally legitimised strong voice for nursing”. However, many interviewees expressed doubt that the establishment of a national nursing chamber is achievable due to varying levels of political opposition in the various federal states.

Apart from increased political voice nursing chambers promise, one nursing director highlighted the need and benefit of regulating the further education and training for nurses. A nursing chamber would, for the first time, imply a (mandatory) central national register and the development of uniform criteria regarding further development and training. Currently, there is solely a voluntary register, initiated by professional associations in recent years. According to interviewees, the number of nurses who get registered this way is low (approximately 5% of nurses) and therefore this initiative *“has zero effect, it’s simply a symbol”*. The fact that no central body monitors the professional further development of nurses is by many regarded as a *“catastrophe”* (interviewee, German Hospital Institute) as the responsibility to ensure adequate further training largely lies with the individual nurse and their respective employing hospitals.

Overall, professional organisations have limited influence over nursing-related matters. In terms of PA, neither trade unions nor professional associations can be observed to actively engage with the topic. There are no publicly available e.g. guidance documents or position statements nor can any other comments be found in relation to this matter. Therefore, there is no evidence

that nursing is either capable of directly influencing PA approaches or that PA is regarded as an important matter.

### *Nurses' education*

Traditionally and currently, training for general nurses is vocational rather than at degree-level (Rogalski et al., 2012). Interviewees frequently noted that, despite common EU regulations for nurses' education, Germany is in fact the last EU country not to have nurses' general training at the higher education level. Consequently, entry requirements are significantly lower than in other countries. This is largely regarded as inappropriate for today's nursing context, although it was acknowledged that the training itself is already of high quality.

*Germany is indeed the only country which has refused at EU level, to improve the entry requirements for nursing* (German Network for Quality Development in Nursing)

Interviewees argued that entry requirements at nursing schools should be increased but in fact were lowered in an attempt to combat recruitment difficulties, and thus the quality of nursing students is declining. This is regarded as inadequate because unsuitable candidates are faced with demanding learning contexts, resulting in high quit/failure rates.

Rather than the academisation of nursing, recent debates revolve around the establishment of a generalised route to become a general nurse, as there are currently three distinct ones for elderly, paediatric and general nurses. The fact that nursing in Germany is still not academised is frequently stated as a contributing factor to the current standing of nursing. Without probing, the perceived link between academisation and professionalisation of nursing was established by interviewees, and the need to make further advancements in this area highlighted. This reflects the general notion in the literature that academisation of nursing and the shift towards higher/university education is a key element in the professionalisation process (e.g. Schmacke, 2006; Kirpal, 2003; Friesacher, 2009).

Several challenges to changing the training system have been highlighted by participants. Firstly, from within nursing some level of resistance can be detected. Current nursing staff are often described as ambivalent towards new staff entering the occupation with a higher degree. Secondly, there are concerns about inter-related factors such as the need to adapt pay scales and job descriptions, especially from the trade union perspective. Thirdly, the lack of prospective students presents itself as a challenge. Raising the standards of education is feared to further exacerbate nursing shortages.

Increasingly though, there is the opportunity of what Rogalski et al. (2012) refer to as tertiary courses of study, particularly for coordinating and leading functions, i.e. managerial positions.

Thus, university courses primarily serve the role of further education, for nurses who want to take up managerial roles or become educators themselves. Friesacher (2009) points to the problematic situation in that academic nursing education in Germany predominantly implies a qualification for patient-distant roles. Thus, academisation has not been yet translated into occupational practice. According to Watkins (2011), overall, in Germany “this lack of educational opportunities coupled with medical dominance inhibits the professionalization of nursing (...)” (Watkins, 2011, p. 2606).

In sum, to assess the current state of nursing in Germany as a factor that will shape PA, the general status, professional organisations and basic educational system have been assessed. These elements largely indicate the level reached within the professionalisation process which may have important implications for PA. The brief characterisation of nursing in Germany indicates that the status of nursing is often described in critical terms due to a lack of academisation, a lack of unity amongst professional associations and low membership levels in professional associations and trade unions. Overall, nursing’s political influence is described as limited. This is also partly attributed the lack of a national regulatory body for nursing, i.e. a nursing chamber. As such, the occupational power to regulate itself and the scope to influence professional norms appears limited. Furthermore, it implies that hospitals must engage with the internal further development and training of nurses to ensure needed skills are developed. This aspect is highly relevant to PA because oftentimes it was suggested that appraisal can be a useful instrument to manage the further development of nurses. No evidence was found that nursing as an occupation actively engages with the topic of PA or that it is able to directly influence this practice. However, as was discussed in the preceding section, the WC to a certain extent compensates for this as it represents nurses alongside other occupational groups at local level.



## 5.2 Prevalence and types of PA for nurses in the hospital sector

Having presented the current situation regarding the general hospital context as well as key national institution that our propositions suggest will influence PA, including the specifics regarding employment relations system in Germany and the status of nursing, this section introduces the different types of PA in the hospital sector and the prevalent type of PA for general nurses. Thereafter, the individual hospital cases will be presented and the impact of the wider national institutional context affecting PA approaches determined.

### *Variants of appraisal and their prevalence for hospital nurses*

Based on the interviews conducted in Germany, it is possible to broadly distinguish between three types of PA used within nursing: firstly, appraisal interviews or more precisely translated “staff discussions” [*Mitarbeitergespräche*], and secondly, target agreement (discussions) [*Zielvereinbarungsgespräche*]. Thirdly, appraisal may be linked to performance-related bonuses (PRBs), i.e. premiums [*Leistungsentgelt*]. Performance bonuses can either be linked to the extent of target-achievement based on a preceding target agreement, or alternatively to a systematic performance evaluation. In general, target agreement discussions imply a more formal approach to staff discussions and the formulation of specific targets. Staff discussions can range from rather open to more structured discussions between the general nurse and direct supervisor. Individual goals can, but do not necessarily have to, be set during staff discussions. Many interviewees made a clear distinction between staff discussions and target discussions and identified staff discussions as different in nature and revolving more around issues concerning personal development, current satisfaction levels on the ward and general feedback. Target agreements have been described as more official and target-orientated, with a focus on measurable targets. Some interviewees used these two terms interchangeably because staff discussions do not preclude the possibility of goal-setting. It emerged from the interviews that nursing directors and possibly nursing (divisional) managers are more likely to have a structured and regular appraisal in the form of target-agreement discussions, compared to ward managers and general nurses. General nurses tend to, if at all, have PA in the form of staff discussions.

National statistics on the use of PA for nurses in hospitals are generally not available in Germany. Therefore, this study replicates part of the British NHS staff survey and collates quantitative data at workplace level. In recent years though, there have been surveys which cover ‘appraisal’ to some extent, though there are uncertainties regarding these in relation to the lack of specification in terms of the position of nurses to which these statistics apply (e.g. managing staff vs. general nurses) and the ownership of participating hospitals. The differentiation

between general nurses vs. managerial staff is important due to suggestions of different prevalent approaches to PA for e.g. nursing directors (i.e. target agreements) and general nurses (i.e. staff discussion). The lack of differentiation between private, public, and non-profit (i.e. church-owned) hospitals is also problematic, since it emerged from the interviews that hospital ownership and its associated philosophy influences the nature of PA. Private hospitals are described to be generally more performance-orientated and thus the nature of PA is described as stricter and more target-orientated than in public or church hospitals. There were also suggestions that the use of PRBs is more common in private sector hospitals.

Nevertheless, according to the 'Hospital barometer', in 2002, 15.6 percent of participating hospitals (n=389) indicated that target-agreements take place within 'nursing and functional services' (DKI, 2002) compared to 45.6 percent (n= 260) in 'nursing' in 2010 (DKI, 2010), which would indicate an overall increase in the use of this instrument. In the 'Hospital Barometer 2012' (DKI, 2012), the focus is specifically on "target agreements/ specifications for leadership roles" only. Here it can be identified that 48.3 percent of hospitals (n=245) use target agreements for nurses in leadership positions, i.e. a similar but higher percentage to that in 2010. The 2010 survey further indicates that staff discussions are used in 79.1 percent cases of participating hospitals within nursing, which certainly indicates that staff discussions are more prevalent. The second larger scale, nation-wide online survey (Bräutigam et al., 2014) only includes one question on target agreements. Again, it does not differentiate between different nursing posts. What it does show is that of 1649 respondents in nursing occupations, just 35.5 percent agreed that 'for my field of activity there are target agreements and I know about them'.

What can be deduced based on these surveys in combination with the interviews is that, although it is difficult to quantify, general nurses are more likely to have staff discussions rather than target agreements, particularly in public hospitals. Higher managerial nursing staff are more likely to have regular individual target agreement discussions. The use of both instruments appears to be increasing, as indicated in interviews. The increase in the use of PA for nurses is generally regarded as a positive and necessary development firstly because it acknowledges the importance of nurses and secondly, it is considered important for nursing to position itself as more 'professional' (e.g. German Nursing Association interviewee). The increase in the use of PA more generally is also connected to the wider hospital environment. The next sections present the first hospital case which uses staff discussion for general nurses and is broadly representative of the most common type of PA for general nurses.

### 5.3 Hospital case No. 1: Appraisal at hospital “Rheinland-Pfalz” (RP)

#### 5.3.1 Background: tradition and type of appraisal

At this hospital staff discussions, also referred to as ‘feedback’-discussions by many participants, are held with general nurses. Yet, staff discussions do not preclude, and indeed often entails, target-setting mostly regarding developmental targets. At this hospital, there is a longer-standing tradition of appraisal for general nurses in the form of staff discussions for at least over a decade, although according to interview participants, over time appraisal has become a more regular, structured and formal process.

#### 5.3.2 Drivers: Institutional factors influencing the approach to PA at hospital RP

##### *Nursing shortages and education system*

During many of the interviews conducted at hospital RP, participants identified key external factors associated with the wider national context as drivers for the approach to appraisal taken, mirroring some of the issue raised by ‘national stakeholder’ participants reflected on in part 5.1. Firstly, interview participants referred to the nursing shortages in Germany and indicated that it influences the way in which appraisal is practiced. Whilst this nursing shortage has many causes, one aspect, according to interviewees, is the lack of new recruits and students willing to learn the occupation, in part due to the status of nursing. Therefore, it was suggested, it becomes more important to use the tool of PA in a way that contributes to the retention of nurses, and avoids further alienation by focusing on the developmental and nurturing aspect of appraisal, and using appraisal as a support and communication mechanism. This notion of PA as a tool to retain staff by providing a framework wherein employees can express themselves was also reflected in national stakeholder interviews and highlighted by e.g. nursing directors of other hospitals who use staff discussions. While staff discussions follow a framework, they do not usually entail strict guidelines and hence provides the scope for managers to utilise them in this developmental manner they see fit. At the same time, there is an acknowledgement that due to this wider context of limited personnel resources, potential negative consequences of appraisal are limited due to the need to work with performance-weaker staff as well which, in turn, makes the focus on development ever more important. Appraisals with a strong assessment and evaluation component are viewed as inappropriate in this context of limited nursing staff due to potential staff alienation, however appraisal in general is regarded even more important to have effective staff.

*...you have to take the employee with you...because you don't get anyone else...(General nurse 12, RP)*

Secondly, the state of the current education system for nurses influences how this hospital and its nursing managers approach the issue of PA. During many interviews conducted, participants identified the current education system for nurses in Germany as a good foundation, however judged it as not sufficient long-term. In addition, the fact that solely limited mandatory training is required once initial vocational training is completed and given the lack of a register or another central body which monitors continuing development for nurses, it is argued, PA lends itself as an instrument to manage the training needs of staff and to “up-school” or up-skill nurses. The need for the continuous development of nurses has become ever so important in the face of fast-paced changes within healthcare and increasing requirements within nursing e.g. due to technological changes within the field. Concurrently, the range of further training courses provided at the hospital has also evolved.

*..vocational training is good..But after that it stops...a lot of ‘up-schooling’ is being attempted through further training and development (ward manager 3, RP)*

*...overall, the interest of hospitals is... to qualify their staff accordingly (ward manager 1, RP)*

#### *Role of the works council*

Thirdly, due to the codetermination rights of WCs in Germany, approval from the WC had to be sought prior to the introduction of formal staff discussions also at this hospital. Thus, the WC had a key role to play by agreeing to the use of this instrument and co-deciding on the nature of PA. Although the TVöD provides the opportunity for linking PAs to performance bonuses (PRBs), one of the key reasons as to why this is not being considered at this hospital is the WC. The nursing director indicated that it would not be possible to reach an agreement with the WC in relation to this matter, given the general stance and philosophy of the WC. Therefore, such an approach was not pursued. Although it did not come to the point that the WC actively resisted the introduction of PA linked to PRBs, the expectation that it would refuse to conclude a works agreement had a similar effect. As the nursing director explained, the WC is very sceptical of measuring performance in an adequate manner, particularly within nursing.

*A works council can destroy an organisation...that's why you have to go about it very sensitively..otherwise you're at war...performance-related bonus...the works council would never agree...it's unbelievably difficult to measure performance in nursing... that's why generally one focuses on reflection and further development (nursing director, hospital RP)*

And indeed, whilst the works councillor interviewed in this case agreed that staff discussions are a useful instrument, the strong view was expressed that within the nursing occupation the adoption of PRBs is unsuitable due to the difficulty of measuring performance and inherent unfairness. Yet, comments by the nursing director also show that this view is shared by the

nursing director. Therefore, the appetite for introducing such a PRB and appraisal system from the side of the employer, under which the nursing director can generally be categorised, is limited. Having said that, the nursing director and other managerial staff have target-agreements for whom these may have monetary consequences in the form of bonuses. Overall, because of the general attitude of the WC and the employer's management philosophy, as well as the context of nursing shortages and the need to manage nurses' training, staff discussions are the preferred type of appraisal at this hospital.

The following section characterises the type of PA in more detail according to the dimension of PA identified in chapter 2, i.e. the purpose, the 'how' and consequences of PA and categorises PA using the established framework to enable further cross-country comparison.

### 5.3.3 Why? Main purposes of appraisal

What can be reported based on the interviews is that the key purpose of appraisal at this hospital is not the appraisal of performance but the further development of staff. When interview participants explained the purpose of appraisal from their perspective and elaborated on the issues discussed during 'staff discussions' several themes emerged, yet all were related to this wider purpose of further development.

#### *Further training & development*

Interviewees described how appraisal is used by ward managers to gauge the interest of staff in different areas of their work and how, based on the employee's wishes, training targets are often agreed. Hence, appraisal is designed predominantly as an opportunity to enquire about how the general nurse wants to develop rather than demanding certain training or targets to be agreed. Whilst a review of the past year occurs, all of those interviewed emphasised that staff discussions serve to look forward regarding how one can and wants to develop and/or which areas on the ward one can contribute to further.

*for me it's really just a very ... developmental discussion... it's about looking forward. (General nurse 5, RP)*

Ward managers' statements are in line with comments by general nurses, who emphasise the discussion around developmental opportunities and supervisory feedback. An integral process regarding the identification of training needs was said to be self-reflection, which is regarded as a valued aspect. While staff ultimately has scope to steer their own personal development, the supervisor/ward manager would usually focus on general nurses' potential and provide suggestions and encouragement on how to further build and expand on their respective strengths and interests.

*..develop, support and challenge..I focus on the strengths...and where can he/she be developed (ward manager 2, RP)*

The focus on training and development as well as encouragement and support is also reflected in appraisal-related documents available on the intranet. A general letter by the CEO, which signifies the importance attached to appraisal at this hospital, accompanying these information sources (see figure 5.2) describes the key characteristics of a 'staff discussion' and shows that it is primarily a personnel development tool which seeks to arrive at a 'supportive development plan' and a 'target-agreement'. It also mentions 'the agreement of future duties and concurrent developmental opportunities'.

**Figure 5.2: Hospital RP: Extract of information provided on intranet (translated)**

**The staff discussion**

Dear Sir or Madame,

the staff discussion is an important management and personnel development tool at "Hospital Rheinland-Pfalz". It ensures that everybody gets the chance to present their performance, and to receive personal feedback from their supervisor. Based on this, a target or task-agreement is concluded, together with a supportive development-plan.

Our employees are entitled to have a staff discussion. They can and should remind their supervisors of their staff discussion. For the first time, it usually occurs [in the form of] as feedback on the impression of the first half year of employment – also in order to verify induction – and thereafter at least once a year.

This involves the mutual evaluation of the fulfilment of current tasks/duties, the quality of teamwork, job satisfaction as well as the agreement of future duties and concurrent developmental opportunities.

These individual agreements are aligned with the goals of the hospital and those of the relevant division. Besides from the gift of feedback within a confidential two-person discussion, staff discussions also lead to increased transparency: people who know what they stand for and know their scope for action, approach their work in a motivated manner, because they are an important part of the whole hospital.

A staff discussion does not have to proceed in a one-sided manner. Also the supervisor can receive feedback about their leadership behaviour.

Follow this common path constructively and committedly and thereby contribute to the advancement of our corporate culture!

Yours,

CEO

Survey results confirm firstly, that appraisal at this hospital is used to formulate targets and set objectives as in total 88 percent (n=77; 2 missing cases) of those who have had an appraisal in the last year replied that it helped them to agree clear objectives for their work. In combination with the interviews these can be suggested to be developmental in nature. Secondly, survey results confirm the focus on the developmental aspect in appraisal. 85 percent (n=78; 1 case missing) of those participants who have had an appraisal in the last 12 months answered 'yes' to the question if any training, learning or development needs were identified. Of those who

answered yes, 95 percent (n=59; 7 cases missing) also agreed that their manager supported them to receive this training.

#### *Support and encouragement*

Another feature of appraisal reported is the discussion and encouragement around possible additional tasks which can be undertaken by the nurse, partly as a result of additional training agreed, thereby widening the scope of activity and responsibility. Conversely, it can be deliberated that certain duties are delegated back. Thus, when the situation arises, that a member of staff feels overwhelmed, appropriate changes can be implemented by disburdening someone of specific tasks. Alternatively, further support can be offered and provided in the form of additional training.

*I of course also want feedback...do they maybe see new areas of responsibility...Or is that what has been put in place too much for someone after all... I always see it as a dialogue. Important is always to present my opinion (General nurse 1, RP)*

Regarding supportive training measures, interview participants referred to training courses such as 'conversation strategies with patients' which can be agreed as goals to support the employee to better cope with challenging patients. Moreover, support in the form of mentoring can be agreed. Particularly at one ward it was reported that certain staff members are trained as mentors, who can then shadow and assist struggling staff for a certain period and provide advice. As such, beyond developing staff further through additional training, a related purpose is the identification and implementation of appropriate supportive measures for the individual nurse.

*...the focal point is always support and help... (ward manager 3, RP)*

#### *Acknowledgement & appreciation*

Another purpose of appraisal which emerged from the interviews relates to acknowledging good performance both verbally and through the use of training-related rewards. As such training does have several functions at this hospital. Certain training courses purely serve to expand nurses' skills and contribute towards personal development, whilst others might represent rewards for good performance. For example, a 'relaxation techniques' course can be regarded as a form of reward and used to show appreciation, especially given the fact that training takes place during working hours. General nurses themselves highlighted the importance of recognition and praise being imparted by the supervisors during staff discussions.

*So reward...Praise on the one side, verbally expressed and also concretely, is there a topic at work which interests you strongly personally? (ward manager 4, RP)*

### *Two-way social exchange*

The opportunity for two-way feedback and a social exchange was highlighted as an objective of appraisal by ward managers and general nurses alike. To have a framework within which staff can voice their opinions is considered an important aspect. Many also commented that when staff provides feedback to supervisors (bottom-up) within the scope of appraisal, it is indeed taken seriously, as suggestions are taken on board and where possible changes are eventually implemented. More generally it was reported that staff discussions serve to strengthen everyday communication. Given the generally busy working environment this aspect is highly valued since a more in-depth conversation and clarification of issues can take place, which can help prevent potential eruption of conflicts or misunderstandings.

*...the 'talking about it'...this social level where it would come to conflicts again and again if it is not being discussed (ward manager 4, RP)*

In sum, the main purpose of appraisal at this hospital revolves around further training and development, as backed up by survey data. A related purpose of appraisal is to provide support via additional training but also e.g. mentoring activities. The delegation and deliberation of extra tasks on the ward is another sub-purpose and is often connected to additional training measures. Training activities and by extension PA also serve as a means to show appreciation and reward staff. Finally, appraisals are conceived as mechanism to provide and receive feedback, i.e. enabling communication between the nurse and the ward manager.

#### 5.3.4 How? Process of appraisal

As discussed in the PA chapter, the main objective of appraisal can be argued to be closely linked to format of PA and how it is exercised. Development-focused appraisal might emphasise the inclusion of personal development plans that “leave room for autonomy” (Beusaert et al., 2011, p. 532; Hemmings, 1992), incorporate coaching/mentoring and be primarily concerned with nurturing staff (Boswell and Boudreau, 1999; Scott and Einstein, 2001). In the case of this hospital, the stated reasons for staff discussions all revolve around staff development and nurturing staff and accordingly the absence of strict performance criteria and close performance monitoring can be identified. Instead an in-built degree of autonomy and choice for the employee but also the manager can be discerned as the structure of appraisal incorporates flexibility regarding its content and potential consequences.

An appraisal form exists (figure 5.3 and 5.4) which provides the basic framework and which leaves a lot of freedom to the manager as to how precisely appraisal is conducted as the discussions do not tend to follow a strict guideline. For the employee too, the appraisal form and preparation sheets (figure 5.5) envisage that he/she contributes to the discussion by



reflecting on certain aspects relating to ones work as well as providing information and feedback to the supervisor. The general themes that the appraisal form contains furthermore reflect the central purpose of staff development. Its design allows the ward manager to customise staff discussions to address the needs of the individual nurse. Given that the appraisal form also comes with a 'notification of agreed developmental measures' (see appendix 1) indicates the goal of establishing a personal development plan. The consensus was that staff discussions are designed in a way that allows for an open two-way discussion that also involves the employee, without the need for extensive documentation. Thus, in relation to the elements in terms of the 'how' dimension of PA established in Chapter 2, the key features of PA at this hospital resembles the 'nurturing' type of PA. PA is strongly future and long-term orientated, concerned with developmental feedback and mutual goal-setting, focused on the individual in terms of comparisons and incorporates high levels of participation and self-determination.

**Figure 5.3: Appraisal Form at Hospital RP (part 1)**

<u>Staff discussion</u>	
<b>Protocol sheet: Staff discussion</b>	
The original will be filed in the personal staff file. Employee and manager will keep a copy.	
<b>Employee:</b>	<b>Manager:</b>
<b>Time period</b> (from – to):	<b>Division:</b>
Staff discussion (Please tick reason for discussion) <input type="checkbox"/> Feedback within the first 6 months of employment <input type="checkbox"/> Feedback –annual discussion <input type="checkbox"/> Reason: .....	
<b>Self-appraisal/Self-estimate Employee (Strengths, Weaknesses):</b>	
COMPETENT – EFFICIENT - INNOVATIVE – COOPERATIVE – CARING (as well as EMPLOYEE MANAGEMENT for managerial staff)	
Please turn over!	

**Figure 5.4: Appraisal form at Hospital RP (part 2)**

<u>Staff discussion</u>		
<b>Appraisal/ Estimation by supervisor (Strengths/Weaknesses):</b>		
COMPETENT – EFFICIENT - INNOVATIVE – COOPERATIVE – CARING (as well as EMPLOYEE MANAGEMENT for managerial staff)		
<b>Feedback to supervisor by employee (if desired):</b>		
<b>Review (In general, Target-achievement from previous year)</b>		
<b>Target-agreement of the employee for the coming year:</b>		
Date	Signature employee	Signature supervisor
.....	.....	.....

In addition, it is noteworthy that many ward managers reported that it is not being rigorously checked whether PAs are actually conducted. General guidelines stipulate that appraisal forms should be filed in the personnel file and that the form entitled “Notification of conducted staff discussion and agreed qualification/training measures” (see appendix 1) should be forwarded to the personnel development/HR department where it is documented that staff discussions have occurred. However, only a minority of ward managers reported that anything is forwarded. While the nursing lead might encourage and inquire that appraisals take place regularly, for the most part the responsibility lies with the respective ward manager. Still, at this hospital, 79 percent of survey participants (n=95; 4 cases missing) confirmed that they have had an appraisal in the last 12 months. Thus, one could argue that appraisals are conducted either because ward managers are indeed convinced of the benefits, or at the request of the general nurse.

**Figure 5.5:**  
**Preparatory**  
**sheets for PA**  
**at Hospital RP**

Staff discussion		Staff discussion	
<b>Preparation sheet for staff for self-reflection</b>		<b>Preparation sheet for the manager</b>	
This preparatory sheet is an aid to help you to prepare for your staff discussion. It is <u>not obligatory</u> and should only be used by you and not passed on to anyone else.		This preparatory sheet is an aid to help you to prepare for your staff discussion. It is <u>not obligatory</u> and should only be used by you and not passed on to anyone else.	
Time period from - to	Division:	Time period from - to	Division:
Staff discussion is conducted on the:		Staff discussion is conducted on the:	
Questions and expectations for the staff discussion:		Questions and expectations for the staff discussion:	
<b>My work tasks and goals:</b>		<b>Work tasks and goals of the employee:</b>	
How satisfied am I with my work tasks and duties?		How satisfied am I with the execution of work tasks and duties?	
Which tasks and goals within my work should be pursued in the next period? What pre-conditions are necessary?		Which tasks and goals should be pursued in the next period? What pre-conditions are necessary?	
Which additional tasks can I take over and which goals do I want to achieve? Can I and do want to hand over?		Which additional tasks should the employee take over and which goals should be achieved? Which tasks should be removed or delegated differently?	
<b>Team-work:</b>		<b>Team-work:</b>	
Am I satisfied with the team-work? What could still be improved?		Am I satisfied with the team-work? What could still be improved?	
Which support do I still need from the team?		Which perspective can I offer my employee?	
Am I satisfied with the leadership behaviour of my supervisor? What feedback do I want to give my supervisor?		<b>My satisfaction:</b>	
<b>My satisfaction:</b>		Are there outstanding issues from the last staff discussion? Are these issues still relevant? Why have they not been changed/worked through?	
Are there outstanding issues from the last staff discussion? Are these issues still relevant? Why have they not been changed/worked through?		Which problems have occurred? What should/could change in the future?	
How satisfied am I with the current work situation and the working environment (e.g. staffing and material resources, workload, work safety, working hours, disruptive factors)?		<b>Staff training:</b>	
<b>My qualifications:</b>		Which qualification and further development measures should the employee make use of. In order to be able to fulfil his/her task?	
Which qualifications do I need to fulfil my tasks? Which qualification and training measures could I make use of?		Which additional qualification measures do I recommend the employee with regard to his/her personal and work-related further development?	
Which additional qualification measures do I want to make use of with regard to my personal and work-related further development/future?		How can I initiate or support the career-planning of my employee?	
<b>My self-estimation with regard to the competencies of the competencies catalogue:</b>		<b>My estimation with regard to the competencies of the competencies catalogue:</b>	
COMPETENT – EFFICIENT – INNOVATIVE – COOPERATIVE – CARING (as well as EMPLOYEE MANAGEMENT for managerial staff)		COMPETENT – EFFICIENT – INNOVATIVE – COOPERATIVE – CARING (as well as EMPLOYEE MANAGEMENT for managerial staff)	
<b>Summary:</b>		<b>Summary:</b>	
How satisfied am I overall with the last year?		How satisfied am I overall with my employee?	
Which changes are the most important to me?		Which changes are the most important to me?	
<b>Other remarks:</b>		<b>Other remarks:</b>	

### 5.3.5 Consequences

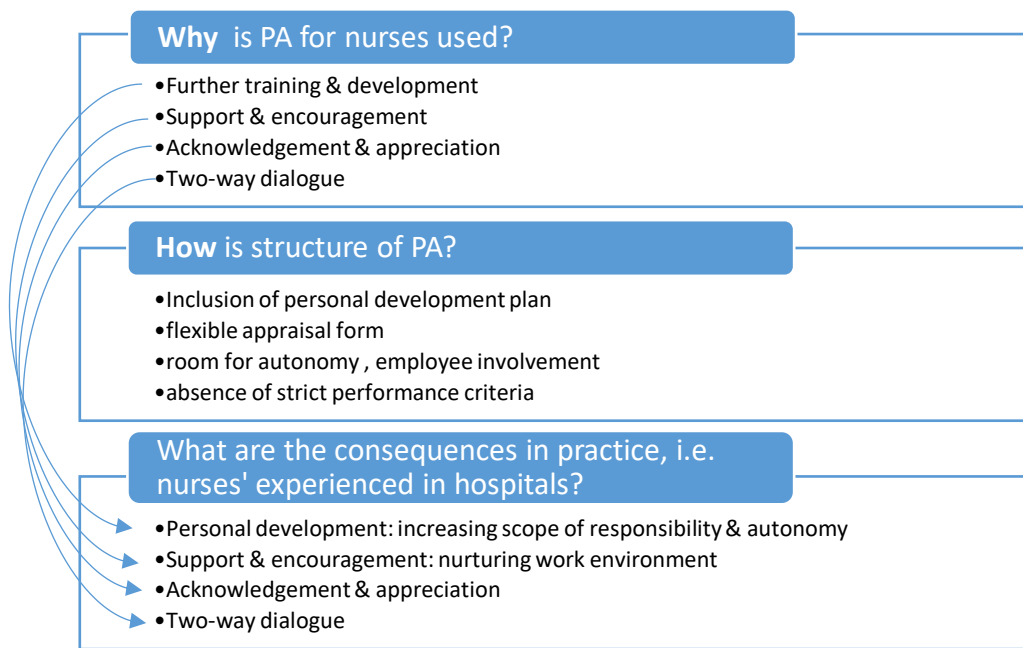
In the case of this hospital, the intended purposes of appraisal match the consequences that have been reported by nurses. In fact, it is difficult to separate the reasons for appraisal from the effects it has on nurses and way it is perceived. In the following the focus is on the consequences of staff discussions for the individual nurse(s), although broader reported consequences for the ward as a whole are also considered.

#### *Personal development: increasing scope of responsibility & autonomy*

As described above, the key function or aim of appraisal relates to staff development, and often involves the setting of training targets. Thus, a clear consequence conveyed within interviews is further personal development and increased individual knowledge. Through additional training that is agreed, many nurses can expand their area of responsibility and thereby their scope of activity and autonomy as they take on additional tasks which are then within their realm. One nurse suggested that by doing so, i.e. providing more varied tasks, the job remains interesting (less “boring”) and nurses remain motivated. Examples given during interviews of additional tasks which can be undertaken were, for example, the role of a student guidance/ practical instructor (for nursing students), the role of a hygiene representative/specialist, the role of a medical products law representative or taking over other areas within the specific field. Indeed, many nurses provided examples in terms of areas they can contribute to more due to their additional training and as a result of appraisal.

Arguably, all this could be argued to have a knock-on effect in terms of how nurses perceive e.g. their level of responsibilities. Survey results show that most nurses are either very satisfied (33.3%) or satisfied (52.5%), or at least neither satisfied nor dissatisfied (11.1%) with ‘the amount of responsibility (...) given’ (n=99). Most participants moreover ‘strongly agree’ (53.5%) or agree (44.4%), or neither agree nor disagree (1%) with the statement ‘I always know what my work responsibilities are’ (n=98; 1 missing). Overall, nurses (n= 99) also agree that they are trusted to do their job (strongly agree: 43.4%; agree: 53.5%; neither/nor: 3%), and indeed no one disagreed with this statement at all. Most nurses (n=99) also indicated to be very satisfied (28.3%) or satisfied (52.5 %) or alternatively neither satisfied nor dissatisfied (13.1) (4.1%: dissatisfied; 0% very dissatisfied) with the opportunities they have to use their skills.

**Figure 5.6: PA at Hospital RP according to dimensions of PA (Hospital RP)**



*Support & encouragement: a more nurturing working environment*

Overall, nurses reported that they perceive appraisal as a nurturing process whereby they are encouraged and supported to further develop their strengths and pursue their interests. Encouragement and a generally supportive stance portrayed by ward managers is a highly valued aspect of appraisal for general nurses. Interview participants conveyed that as a consequence of appraisal supportive measures can be put in place, whether in the form of mentoring or a developmental plan, which positively affects the nurse who is then better able to deal for example with challenging situations.

The notion that nurses' immediate managers are usually regarded as supportive is reflected in the survey data, where 23.2 percent indicated that they are very satisfied, and 57.6 percent satisfied (n=99) in relation to 'The support I get from my immediate manager'. No one indicated to be very dissatisfied, 9.1 percent indicated to be neither satisfied nor dissatisfied, but 10.1 percent indicated to be dissatisfied.

One ward manager reported of an example where additional training was agreed with a nurse, who subsequently to undertaking the specific course felt a sense of pride in her new abilities. Again, also general nurses themselves described appraisal as an encouraging and nurturing process which contributes to an overall supportive working environment, as staff is free to discuss challenges they face and express interests in terms of developmental opportunities. Furthermore, for nurses, appraisal means that they can reflect not only on their work in a more

structured manner but also their career and engage with their own career planning. As many nurses suggested, without these annual discussions, there would be no other occasion at which one would be able to reflect on such issues in depth.

*[the manager] then pointed it out and said 'look, there is a course. How about it?'...And that was very very interesting for me and very developmental/encouraging/ nurturing for me. (General nurse 11, RP)*

#### *Acknowledgement & appreciation: Feeling taken seriously, valued, and reassured*

It was mentioned above that appraisal seeks to impart acknowledgement in the form of praise and in certain cases through training-related “rewards”. Indeed, nurses reported the importance of receiving positive feedback and verbal praise during appraisal/staff discussions, as this makes them feel reassured and more appreciated, especially when at the beginning of their career. Especially given that everyday-life at the ward is considered fast-paced and stressful, nurses commented on the fact that at least once a year time is allocated specifically for the individual for these discussions which in itself is described as appreciative.

*it feels good to hear once a year ‘.. you’re doing a really great job’. That’s simply good, to get a recognition/acknowledgement, especially in such a stressful occupation. (General nurse 5, RP)*

Survey data confirms that in most cases, appraisal leaves nurses feeling that their work is valued by their organisation, as 79 percent (n=77; 2 cases missing) of those who have had an appraisal in the last year answered yes to this question. Similarly, regarding the statement ‘The recognition I get from good work’, of those participants who responded (n=98; 1 missing), most nurses indicated that they are either very satisfied (18.4%), or satisfied (45.9%). 14.3 percent indicated to be neither satisfied nor dissatisfied and just 6.1 percent to be very dissatisfied and 15.3 percent to be dissatisfied. Likewise, regarding the statement ‘The extent to which my organisation values my work’ the majority of nurses (n=97; 2 missing cases) indicated that they were either very satisfied (18.6%) or satisfied (52.6%), or neither nor (12.4%) rather than dissatisfied (13.4%) or indeed very dissatisfied (3.1%).

In addition, ward managers suggested that appraisal ultimately contributes towards the retention of their staff, which has become an increasingly important issue in the context of nursing shortages, because they provide an opportunity to impart individual praise within a more formal framework and recognise nurses’ contribution to the ward and team, thereby making staff feel more appreciated. As training opportunities are discussed, staff can get a better sense in which direction one could develop within their field.

### *Two-way social exchange: Communication*

The overall positive effect on communication was also noted by many interview participants. As has been reported, appraisal serves as a platform to provide (developmental) feedback to nurses. Survey results show that most of those nurses who participated (n=99) either strongly agreed (36.4%) or agreed (49.5) with the statement “My immediate supervisor gives me clear feedback on my work” while 10.1 percent neither agreed or disagreed with this notion and just 4 percent disagreed, and no one strongly disagreed.

Management feedback is also an integral part of appraisal, which was furthermore highlighted as an indication that the opinion of staff matters and is valued. Nurses’ feedback can also affect the whole ward, as it was reported that staff suggestions are indeed often implemented and taken on board, further contributing to the feeling of being taken seriously.

*...a lot of little things have changed...which was based on the suggestions of staff here..so [it] is paid attention to...it’s taken seriously... (general nurse 7, RP)*

Both ward managers and general nurses suggested that the yearly staff discussions have a positive impact on communication overall, as staff feels more comfortable to approach their respective supervisors also during the year. Again, the opportunity to have a platform to discuss issues in more detail has not only been said to prevent misunderstandings from escalating but is perceived to be conducive for a more positive working environment.

*It is also nurturing as well, that we talk regularly with each other... (ward manager 2, RP)*

### *Optimise processes*

The final perceived consequence of appraisal mentioned, although to a lesser extent than the developmental aspect, was that it can ultimately help to “optimise [work] processes” and improve the quality of services provided. According to interview participants, appraisal aids the optimisation of work processes by providing an opportunity to discuss such processes and the way in which staff can contribute towards improving them. This again relates back to development of staff and the discussion around tasks the employee can be in charge of. Ultimately, appraisal is also useful to talk about the themes of the ward and how those can be moved forward through the involvement of staff.

Survey data confirms that nurses tend to view appraisal as useful in terms of improving their own performance: of those survey participants who indicated that they have had an appraisal in the last 12 months, 76 percent (n=75; 4 cases missing), answered ‘yes’ to the question ‘Did it [appraisal] help you to improve how you do your job’. Both ward managers and general nurses



themselves recognised that staff discussions enable a reflection to take place which can have positive effects on performance.

*that one doesn't just work like that but that one thinks about it consciously...That one really works in a more structured way and discusses it with the superior, whether it's sensible that way or if there are other, better bases... (General nurse 5, RP)*

Furthermore, it became apparent that for ward managers, appraisal is a useful tool to plan staff development and anticipate role allocations on the ward, as further training is often linked to the undertaking of further tasks. In that way, appraisal serves as a way of conducting more efficient personnel planning by ward managers, an aspect which is particularly relevant in the context of nursing shortages.

*Staff discussions are important to be able to steer processes, so that no one tags along...that processes are optimised, that there are no idle capacities...that it's managed...in the course of limited resources.. (ward manager 2, RP)*

#### *Potentially limited effect*

What also emerged during interviews by some is that it is possible that appraisal has limited consequences because it is not necessary to agree targets at all if all expectations have been met and there is no interest from the side of the employee. In any case, appraisal at this hospital does not have the potential to have any negative consequences. In this context, one head nurse/ward manager alluded to the wider context of personnel shortages which contributes to nurses being typically evaluated in positive terms and rather leniently, both during their apprenticeship and appraisal, mainly to avoid alienating people from nursing. As such, from this perspective, consequences are limited and predominantly relate to further training but no drastic measures. This was also the conclusion of some general nurses who are aware that the main possible but not necessary outcome solely relates to further training. Thus, appraisal may have little impact, particularly for nurses with long organisational tenure and no interest in further development.

*At the end of the day it has...no consequences...(General nurse 12, RP)*

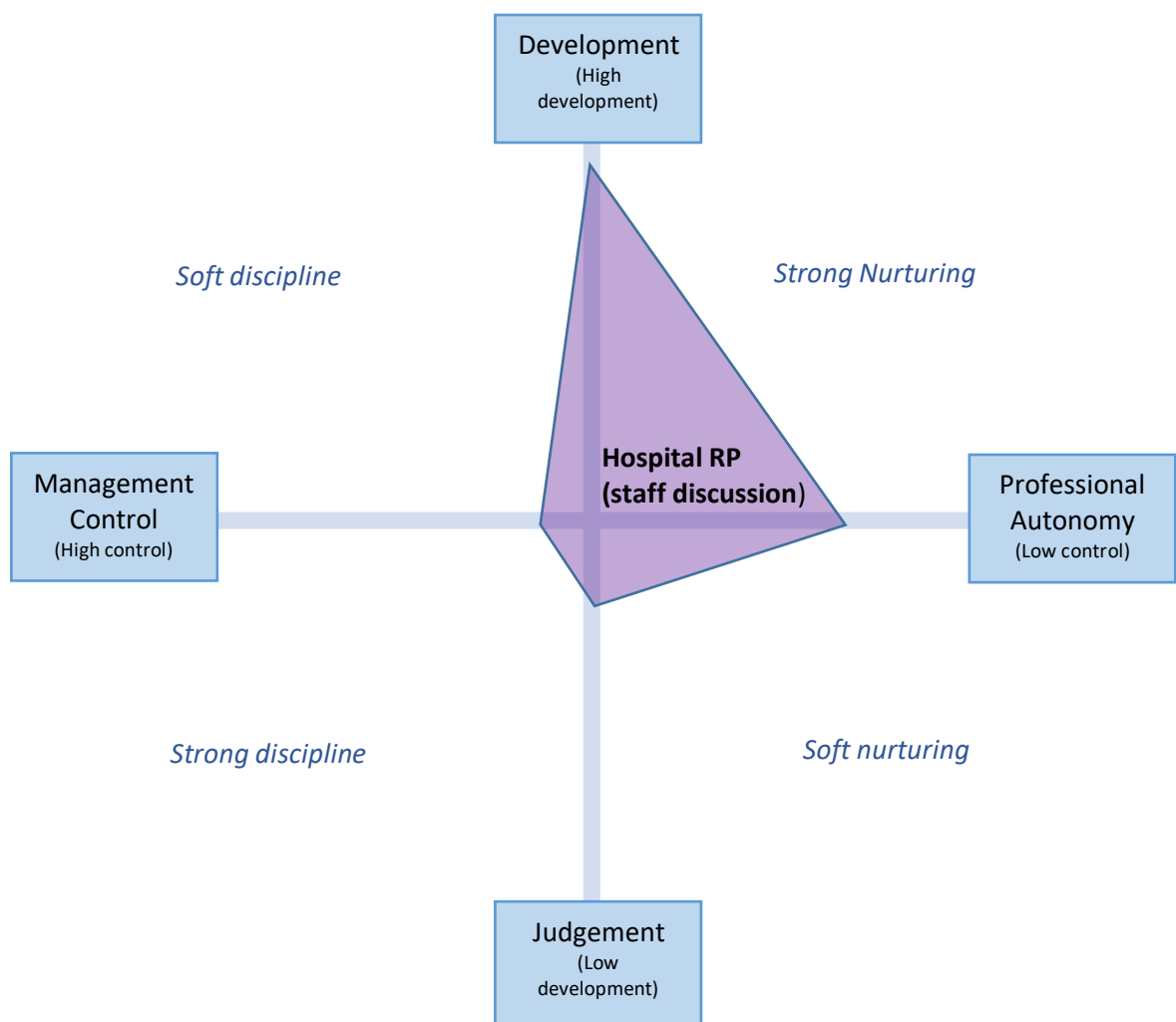
*there are big problems in terms of that the scope of performance evaluation is not fully exhausted, so that one always evaluates at very good levels...One is in a certain desperate situation, that we'd need a lot of personnel but having also little opportunities...to evaluate in a way that it would have consequences. (ward manager 1, RP)*



### 5.3.6 Summary and conclusion

In order to categorise the type of PA at this hospital using the analytical framework introduced in chapter 2, firstly each hospital case was analysed by comparing the 4 dimensions and the sub-dimensions (provided in table 2.3 and 2.4) within the particular case. The second stage of analysis was to compare across the four cases on each dimension to guarantee consistency across cases. Based on the findings of this hospital and taking into consideration framework for comparison, it can be concluded that appraisal at this hospital can be predominantly categorised as ‘developmental and nurturing’, i.e. mostly orientated towards ‘strong nurturing’ as illustrated in the figure below. This is reflected in the emphasis placed on this aspect of appraisal during interviews as well as in the appraisal-related documents and is furthermore reflected in the survey data. Indeed, staff development can be identified to be simultaneously the main purpose and outcome of appraisal at this hospital.

**Figure 5.7: Framework for comparison: Hospital RP**



Source: Author's own compilation

Yet, alongside the predominant 'development' aspect, appraisal also entails elements of evaluation and judgement. Firstly, the individual nurse should reflect on and evaluate his/her own competencies, a process which is envisaged to begin during the preparation phase. Secondly, even if subtly, to arrive at a target-agreement concerned with further training and development prerequisites the supervisor to make judgements on the strengths and weaknesses of individual staff members. Therefore, despite the developmental focus, elements of judgements are still present. The fact that even development-orientated forms of PA include elements of judgement/evaluation in relation to the assessment of the individual's strength and weaknesses is an acknowledged aspect in the PA literature (e.g. Boswell and Boudreau, 2002).

In addition, although ward managers seek the commitment of their staff more generally, also regarding specific target agreements, it can be discerned in comments made that an underlying goal for managers is to better manage their 'resources' and "steer processes". This includes the distribution of additional tasks which need to be allocated appropriately. The further development of the individual nurse often can, but does not have to, lead to an expansion in their field of responsibility and autonomy. Although undertaking additional duties might be encouraged by the supervisor, it is ultimately under the discretion of the individual nurse to decide. In fact, it emerged that PA may potentially have limited consequences. Particularly nurses with long tenure, it is argued, might not benefit as greatly from staff discussions and e.g. career planning and personal development as those at the beginning of their career.

Overall, the findings at this hospital reflect the literature on PA which acknowledges the possibility of a more suitable, 'professional' (e.g. Fitzgerald, Youngs, Grootenboer, 2003) or "appraisee centred" approach to PA (Conlon, 2003) and highlights the benefits of PA in relation to increased motivation, commitment, positive staff attitudes and ultimately work performance (Kuvaas, 2007; Posthuma and Campion, 2008; Boswell and Boudreau, 2002; Wilson and Western, 2000) via an emphasis on development, coaching, and positive supervision (Martinez and Martineau, 2001). The hospital case also exemplifies that developmental PA appeals to those intrinsically motivated (Daley, 1992), as typical for public sector workers and nurses, and that training opportunities are valued by staff as a non-financial, personal rewards (Krausert, 2009; Northcott, 1997). The participative nature can be argued to have contributed to the general acceptance and positive attitudes toward PA at this hospital, in line with suggestions by e.g. Kim and Holzer (2016). Further than that, as suggested by West et al. (2006) specifically in the hospital context, development-orientated PA contributes to positive feelings such as feelings of appreciation and being valued (West et al., 2006) as were most nurses in this case.

Reflecting back on the external drivers, i.e. the national institutional factors and how they contributed to the hospital's PA approach, the focus on further training and development can be explained by, in part, the education system for nurses and the stated need to "up-skill" them as well as the lack of a nursing chamber overseeing the continuing professional development of nurses. This compelled the hospital to use PA in the form of staff discussions which focuses on this area. Particularly in the context of nursing shortages and the lowered entry requirements for nursing students, the role of further development and continuing guidance has arguably increased. Moreover, PA in the form of staff discussion at this hospital is seen as contributing towards the retention of nurses which, again, has become more important in the context of nursing shortages. Furthermore, given the influential role of the WC, who had to approve the system of PA, and the specific employer-works council relations at this hospital means that the WC would have not approved a more 'discipline'-orientated form of PA. Moreover, due to the WC the appraisal system is set up in a way that gives ward managers guidelines yet scope to implement PA in an individualised way which contributes to the internal ownership of the system. In turn, ward manager can be suggested to try and redress the lack of influence and status of nursing (identified in national-level interviews) at local level by encouraging more engagement via developmental forms of PA.

## 5.4 Hospital case No. 2: Appraisal at hospital “Nordrhein-Westfalen” (NRW)

### 5.4.1 Background: Tradition and type(s) of appraisal

In recent years, hospital “Nordrhein-Westfalen” (NRW) changed its approach to PA significantly. In essence, this particular hospital initially had no tradition of regular, structured PA. Then, it introduced an individual PA system linked to performance-related bonuses (PRBs). While in operation, this system also shifted from ‘systematic performance evaluations’ to a system of individual target-agreements in later years. Subsequently this has been replaced by the use of team targets and team-bonuses, with staff discussion being a complementary but non-obligatory feature.

The fact that this hospital used to operate a system of PA linked to individual bonuses makes this an unusual case and is thus not representative of most German public hospitals. National stakeholder interviewees and participants of this hospital suggested that the adoption of this system is indeed not very common in this sector. Nevertheless, this hospital case shows that even here, the system of PA linked to PRBs did not prevail and underscores the point of a general tendency in German hospitals to adopt more nurturing approaches to PA in the form of staff discussions which hospital NRW has begun to initiate now. Having said that, even a system whereby bonuses are distributed based on team performance was not reported elsewhere and is thus exceptional. In the following sections, both the former and current approach to PA will be presented, including the institutional drivers that have led to the particular PA approach in relation to the three dimensions, i.e. the ‘why’, ‘how’ and consequences of PA. Then, each approach will be categorised using the framework established in chapter 2.

### 5.4.2 Drivers: Institutional factors having led to *former* PA approach at hospital NRW

#### *Collective bargaining agreement and lack of pay differentiation*

Key external factors associated with the wider national context can be identified to have led to the adoption of PA linked to individual PRBs. The first influencing factor relates to changes to the TVöD, combined with the employer’s initiative to utilise this possibility. The chairman of the WC, the former and new deputy nursing director and managing director all alluded to the opportunity which had arisen with this new provision in the TVöD. Due to a general lack of pay differentiation within nursing, the employer was particularly keen to introduce incentive-based appraisal to provide tangible rewards for staff. The fact that the managing director is actively involved in negotiations as chairman of the (regional) Association of communal employers might have contributed toward the awareness of wage-problematics.

### *Role of works council*

Secondly, the WC emerged yet again as an important actor. The WCs' authorisation in the form of a works agreement is a pre-condition for the introduction PRBs and was suggested to only have been possible due to the general stance of this particular WC and existing cooperative employer-work council relations.

*Such things always have to go through the works council. [It] is involved in this whole...these ideas, these strategic developments, that's always only possible together with the works council.* (Deputy nursing director 2, April 2016)

Although it was reported that the WC was sceptical at first, through a process of communication and negotiation it was possible to reach an agreement and eventually introduce PA linked to individual PRBs. The former deputy nursing director attributes this largely to the WC's philosophy and general willingness to cooperate. The nursing director and the managing director both referred to the cooperative relation with the WC and the fact that not many WCs in Germany are supportive of such undertakings. It was reiterated that in Germany in general, hospital WCs are very critical of PRB systems and thus usually strongly resist or "strategically boycott" any attempts to adopt such a system. It was further referred to other instances where hospitals were either unable to convince their WCs or where the management did not even attempt to convince their WCs. As such, it was highlighted that this particular hospital was an exceptional case thanks to its WC which was identified to be more inclined towards cooperation.

*The question is, what kind of philosophy a works council has...* (Deputy nursing director 1, NRW)

In addition to being involved in the set-up of the general framework of the system, the WC is also responsible for overseeing the implementation of the bonus system through the internal committee or working commission (Betriebliche Kommission). During interviews, it was indicated that the employer side regards the involvement of the WC as genuinely valuable as it was referred to the positive contribution it can have in regulating such a system. According to the new deputy nursing director (2), also regarding any strategic changes to the instrument the WC plays a role. Related to this, the WC representative emphasised the evolving nature of the instrument and the need to regularly review and continuously develop an "adaptive system", especially due to concerns that, despite the agreement reached with the employer, still remained from the perspective of the WC.

The WC representative interviewed confirmed their involvement in the agreement and set-up of the general framework for the PA system. The works councillor also identified that the WC's view of its own role certainly contributes to the cooperative relations at this hospital. Although

there are certain issues which, according to the works councillor, are non-negotiable, the WC remains relatively open towards discussions regarding other matters, including appraisal-related issues. Essentially because the WC sees its own role as preserving jobs and the terms and conditions of employment under public ownership, by cooperating it hopes to ultimately lessen the threats of privatisation which exist more widely.

*we need to cooperate reasonably because the works council (WC) has the task to preserve jobs...I see the role of the WC not like that one runs around the place with a bat but that one discusses it sensibly and objectively...What's legally feasible, we do...it differs from hospital to hospital in Germany..the employer also wants to achieve his goals, then it makes sense that one does this together (chairman of the works council, "NRW")*

The fact that the WC had cooperated thus emerged to be related to underlying generic pressures. These pressures are related to those described in section 5.1, namely the fact that hospitals are under financial pressure to perform and ultimately the threat of privatisation exists. Since employment conditions are generally better in public hospitals, the WC seeks to remain in municipal ownership and thus is motivated to work together with the employer where feasible. As its main perceived function is to preserve jobs and terms and conditions of employment, despite concerns about the use of PRBs the WC ultimately opted to cooperate on this issue. This finding is in line with suggestions in the literature that employer-WC relations may vary between hospitals in part depending on the particular employers' and WCs' attitudes and the broader context (Greer et al., 2010).

*...one could also do without the performance bonus...Everybody wants to preserve their jobs, if it's possible, that we remain in communal ownership...in Germany especially, the increase in private hospitals has increased enormously...competition is surely also very tough...if we, because of the general conditions, are in the red...it could certainly be that...our shareholders say 'we rather sell this with the debt'...We're stretching ourselves in all areas...[that's why] what's possible within the scope of the collective bargaining agreement and of the money, we do [it]. (WC representative, NRW)*

### 5.4.3 Why? Main (intended) purposes of appraisal

The introduction of individual PA linked to PRBs was preceded by a works agreement between management and the WC. This workplace-level agreement lists a diverse range of objectives (see extract below). The vast list of purposes revolves around improved quality of services and increased efficiency on the one hand, and staff motivation and development on the other. These intended purposes were also echoed in interviews conducted with higher-level managerial staff, who were involved in the decision to introduce this system (i.e. managing director, deputy nursing director, works councillor), although here the focus tended to be more on the motivational potential. The intended purposes will be briefly highlighted in more detail.

Figure 5.8: Hospital NRW: Extract of works agreement

Section "Intention of performance and results- orientated pay (bonuses)

- |   |
|---|
| <p>(1) Performance and/or results- oriented pay (bonuses) should, in accordance with § 18 paragraph 1, Sentence 1 TVöD, improve in-house services, increase the effectiveness and efficiency of the organisation and processes (...) and at the same time strengthen the motivation, personal responsibility and leadership skills of employees of the company.</p> <p>(2) An improvement of the in-house services is evident e.g. in a better quality of service or customer friendliness, which can be particularly measured on</p> <ul style="list-style-type: none"><li>- quality of the treatment, quality of care, and quality of stay</li><li>- improved public image</li><li>- transparency of procedures</li><li>- patient satisfaction</li></ul> <p>(3) An improvement in economic efficiency/viability can be determined by</p> <ul style="list-style-type: none"><li>- Optimised workflows</li><li>- increase of productivity</li><li>- Increases in both service quantity and turnover</li><li>- Improvement of income / revenue</li><li>- Reduction of process and unit costs</li><li>- Avoiding cost increases / tax increases</li></ul> |
|---|

### *Appreciation & Motivation*

Particularly the managing and deputy nursing directors interviewed emphasised the symbolic nature of the bonus and described its main function as providing recognition or appreciation. Although the amount of the bonus was not regarded as large (about 200-300 Euro gross p.a.; 150 Euro net), the fact that a reward was given at all was argued to be important. In addition, given that the payment of PRBs prerequisites appraisal in the form of an evaluative discussion, another objective was to increase communication between the supervisor and employee. It was suggested that this system offers a framework whereby praise and recognition could be given and good performance acknowledged in a verbal as well as tangible way, reinforcing the emphasis on employee appreciation. According to those involved in the introduction of the system, the tangible (bonus) and less tangible (praise) forms of appreciation would lead to increased staff motivation. Moreover, it was intended that as payment would also become

somewhat fairer, staff motivation could furthermore be increased. The risks of feelings of punishment in the cases of poorer performances and lower bonus payments was argued not to be a major issue because in financial terms the difference between receiving the full or partial bonus would not be significant.

*[so that] the employee...feels taken seriously and valued, that one...says...‘well done’...not the money alone...but the fact that..managers discuss these things together with their staff...makes a difference. (Managing Director, NRW)*

*...small recognition of several hundred euros...payment becomes fairer...employees, who get a little bit more money see themselves affirmed in their performance...They’re happy (Deputy nursing director 1, NRW)*

#### *Better performance & improved quality*

A further stated aim, also reflected in the works agreement, however less emphasised in the interviews than the motivational aspect, was to improve processes relating to the employees’ work at the ward, their overall work performance, and by extension the quality of care provided and patient satisfaction more broadly. One of the arguments, was that better work performance is encouraged through the use of a reward/bonus which ultimately benefits hospital patients.

#### *Further training & qualifications*

A final, but not predominant, stated intended aim of this type of appraisal mentioned by higher managerial level interview participants relates to personnel development, i.e. the further development of staff. The works councillor reported that further training was one of the criteria based on which a nurse would have been evaluated and as such an element of this PA system.

#### *5.4.4 How? Process of appraisal*

Regarding the structural features of the PA system, the main issue was ‘evaluation’ since PA was a reward-driven process linked to individual PRBs. As the appraisal form used shows (see figure 5.10 and 5.11 below), staff was evaluated and judged according to a pre-determined set of relatively broadly formulated criteria, each of which would have been assessed on a scale from 1 to 10. This evaluation form was accompanied by a catalogue which more clearly defined each criterion for each possible score and a description for managers on how to use the form. Each interview participant was very aware of the form and consistent in the way they described the process of evaluation. The following quote is representative of the way in which the general procedure of appraisal has been described.

*..the supervisor thought in advance about the assessment...informed the employee about that during the discussion...and...then [the form] was signed and depending on how high the evaluation was, the more money one got. (Divisional manager 3, NRW)*



**Figure 5.9: Appraisal form at Hospital NRW (individual-based evaluation) – Part 1**

Appraisal sheet		
Evaluation for:		
Ward:		
Evaluation from:		
	Evaluation	Total
<b>Work results</b>		
Work quantity and quality		
Practical skills		
Theoretical skills		
Effectiveness/ Target-achievement		
<b>Independence/ operational readiness</b>		
Working independently		
Collaborative thinking/ taking initiative		
Willingness to take on responsibility		
Motivation/ commitment		
<b>Working behaviour</b>		
Flexibility		
Broad readiness for action		
Creativity		
Organisational and coordination skills		
<b>Team-work</b>		
Interaction with patients, relatives, customers		
Interaction with colleagues/ team-working		
Interaction with superiors		
Information exchange		
Conflict behaviour		
<b>Ability/willingness to learn</b>		
Participation in further professional development/ continuing training		
Participation in further/ advanced training		
<b>Leadership behaviour</b> (for staff with management tasks)		
Persuasive skills/ communication skills		
Assertiveness skills		
Motivational capability		
Work planning/ scheduling		
Evaluation result:	0,00	
Target achievement rate:	0,00%	

**Figure 5.10: Appraisal form at Hospital NRW (individual-based evaluation) – Part 2**

Surname: _____	Name: _____
D.o.b.: _____	Current grouping: _____
Job title: _____	Department/ward: _____
Evaluation period: _____	Evaluation from: _____

Reason of evaluation:

<input type="checkbox"/> During probationary period	<input type="checkbox"/> End of probationary period
<input type="checkbox"/> Early scale increase	<input type="checkbox"/> Postponement of scale increase
<input type="checkbox"/> Annual performance evaluation	<input type="checkbox"/> Change of job within the hospital
<input type="checkbox"/> Termination of the employment relationship	<input type="checkbox"/> Other: _____

Activities according to job description: \_\_\_\_\_

Further activities:

Comments

Particularly notable achievements and skills

I acknowledge the evaluation. The evaluation was discussed with me. I am aware that I am entitled to lodge an objection in writing. I received a copy of the evaluation.

Date: \_\_\_\_\_ Supervisor: \_\_\_\_\_ Employee: \_\_\_\_\_

The works agreement indicates (see extract below) that the hospital originally sought to move from individual ‘systematic performance evaluations’ to individual target agreements in the long term. The wording of the works agreement was such that it provided some scope of flexibility regarding the concrete implementation of PA. The rationale for individual target agreements rather than performance evaluations typically revolves around target agreements being better

suited to align employees' interests and actions with the objectives of the organisation (e.g. Kampkötter et al., 2017), which was also argued in this case by interviewees. Further it was suggested that target agreements enable a more individualised approach. One specific divisional manager (divisional manager 3) confirmed that after a few years the system of systematic performance evaluations was replaced by target-agreement discussions for each nurse. However, this latter system lasted for only about one year and was abolished soon after and with it individual-focused appraisal connected to bonuses overall.

**Figure 5.11: Extract of works agreement, section "Procedure for distribution" (Hospital NRW)**

*"Collectively agreed performance bonuses will be principally paid as performance premiums until further notice. The payment shall in the long-term principally occur on the basis of target-agreements. The distribution on the basis of systematic performance evaluations will be accepted for the time being, but shall become the exception in the medium term."*

Overall, in relation to the elements regarding the 'how' dimension of PA established in Chapter 2, the key features of PA in this case resembles the 'discipline' orientated type of PA which focuses on past performance, pre-set criteria, with minimum concern for training and development, apart from it being one of many points being assessed. Most importantly, it used financial bonuses to reward or in effect punish depending on performance outcomes and provided little room for participation.

#### 5.4.5 Consequences

The clear majority of interview participants, including ward/divisional managers and general nurses alike, spoke critically of the system and expressed the primarily negative effects it had on them and their teams. Most were clear in their assertion that the negative consequences ultimately outweighed any potential benefits. Also, more widely, it was recognised that the system overall emerged as inefficient and difficult to implement.

#### *Competition & resentment*

The key unintended negative consequence, raised by most nurses, was that staff compared their evaluation results amongst each other, which in turn led to resentment within the team. Furthermore, the system of point-based evaluation was reported to be detrimental to team-work as it caused competition within the teams which was negatively perceived by nurses. This did not only cause frictions between general nursing staff, but likewise between the supervisors and their staff. This was considered problematic since team-work is seen as vital within the nursing occupation.

*then there was such a competitive battle: who's the better one... (General nurse 4, NRW)*

*there was a lot of friction and...resentment...I didn't feel good with it (General Nurse 5, NRW)*

#### *Pressure, judgement & control*

It was reported that this type of appraisal increased the perceived pressure and control due to feelings of being monitored. There was an understanding that evaluation pre-necessitated the monitoring of nurses' work to make a judgement with regard to the performance criteria. Overall, the fact that points not unlike grades were given and due to feelings of being monitored, many nurses not only experienced performance pressures but also perceived the process as degrading, unappreciative and demotivating. Especially given the context of nursing shortages, many nurses felt they have reached their tipping point.

*for me it's got something to do with pressure...one felt like being pigeonholed, and then this monitoring...I absolutely felt controlled and not understood (General nurse 3, NRW)*

#### *Perceived unfairness due to type of questions & subjectivity*

Another issue raised was the perceived subjectivity inherent in performance evaluations which left scope for potential biases. Many participants alluded to the perceived negativity bias, where impressions of bad performances had an impact on evaluations, although these instances of below-average performance were not representative of their overall performance. Affected staff was dissatisfied with the type of questions and criteria as these were considered as not particularly relevant. Therefore, it was suggested, results did not fully reflect actual performance. It was also reported that the nature of questions could be discriminatory for older nursing staff, who would have more difficulties to achieve full points, as the quote below illustrates. This was linked to the view that the criteria were too broad, making it necessary for the manager to interpret their meaning.

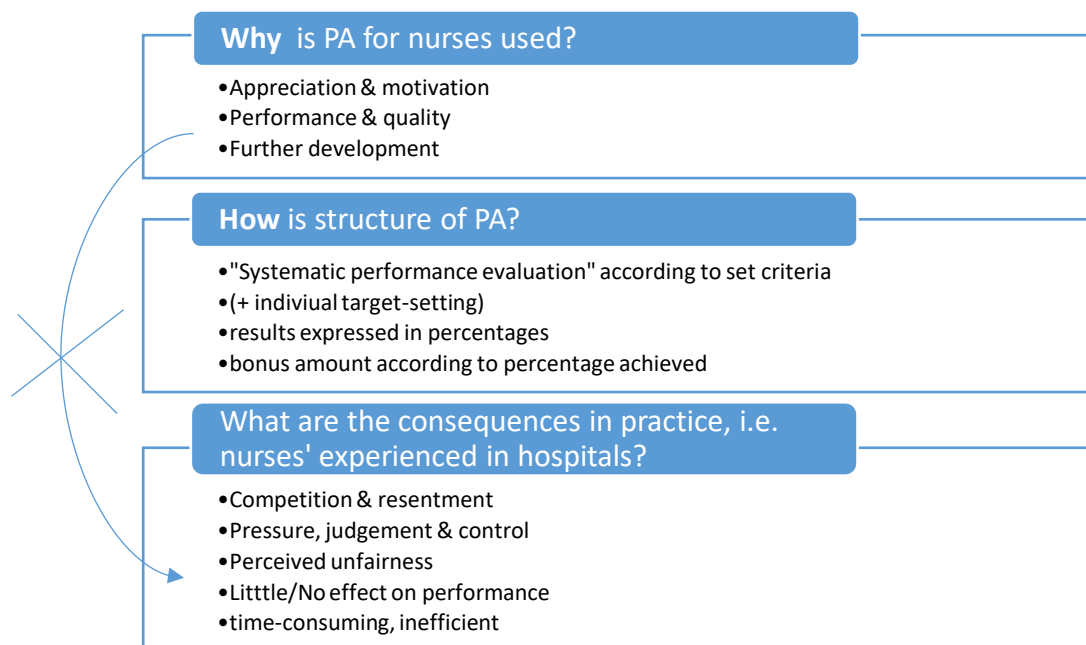
*it was said:...'could you work a little faster'...I'm perhaps different to the ones...in their early 20s...I'm not a machine...we work with acute situations, with people who are dying...it's not fair in such an [occupation] (General nurse 6, NRW)*

Although survey data of this hospital is based on a small sample (n=26), it could be argued that this individual PA system still has a lasting impact on e.g. the way in which nurses perceive 'the extent to which my organisation values my work'. Regarding this statement, 26.9 percent indicated that they are dissatisfied and 19.2 percent that they are very dissatisfied while 15.4 are neither/nor. Only 7.7 percent are very satisfied, although 30.8 percent are satisfied. At the same time, nurses have not become more satisfied with their pay. The survey results indicate that 30.8 percent are dissatisfied, 19.2 percent even very dissatisfied, 15.4 neither nor, just 3.8 percent very satisfied and 30.8 percent satisfied with their levels of pay.

### Time consuming

From the perspective of nursing managers, a key issue articulated was the amount of time it took to complete evaluations for each member of staff as well as the timing of those evaluations, as each had to occur at the same time of the year. As the system for individual evaluations shifted to individual target agreements, practice had shown that the type of targets set tended to be mundane tasks, as it was challenging to agree further-reaching goals especially for part-time staff. Essentially however, there was the realisation, also from the employer-side, that neither system of individual PA linked to bonuses was sufficiently efficient to maintain nor entirely appropriate and therefore was eventually abandoned in favour of a team-based appraisal and individual staff discussions.

**Figure 5.12: PA at Hospital NRW according to dimensions of PA (individual-based PA)**



#### 5.4.6 Drivers: Institutional factors influencing *current* approach to PA at hospital NRW

The system of individual PA linked to PRBs was eventually abandoned, due to the unintended consequences which emerged, and transformed into a system that focuses on team-targets and team-bonuses. The term 'team' in this case implies the nursing team of a particular ward. This involves holding twice-yearly team events, so-called team-days, during which team-targets are communicated to and discussed with the team. In addition, individual staff discussions can be conducted but this is no longer compulsory or linked to PRBs. The hospital had some previous experience with larger-scale team discussions within the psychiatric unit of the hospital.

Apart from the pivotal role of the WC in agreeing to a works agreement for the use of PRBs initially, on the employer side the nursing director can also be identified as a key actor. The works agreement leaves scope within the occupational areas to adjust the performance-bonus system which the WC representative emphasised was the original intention and that PA should be an “*adaptive system*” which should be further developed and adjusted continuously. The move away from the bonus system based on *individual* performance evaluations coincided with the arrival of a new nursing director.

*our nursing director changed...because of that, the whole system was changed as well*  
(General nurse 4, former student apprentice)

*That came from the nursing director this change...*(Divisional manager 3, NRW).

Yet, the executive management and the WC have also been supportive of the shift toward team-related targets and bonuses in an effort to eliminate the unintended consequences of the former system. Indeed, during interviews it was frequently alluded to the fact that there was a general realisation of the unintended consequences the individual-based system brought about. From the employer perspective, the inefficiency of the system was an important concern (e.g. in terms time/cost-effort, i.e. timing of individual evaluations, difficulty of establishing meaningful targets for all individual nurses, lack of performance improvements) and from the WC perspective, the general dissatisfaction of staff. As the new nursing director ‘came’ from the psychiatric unit and had experience with the team-orientated system (without the team-bonus component), in co-operation with the WC the new system was implemented. It was also reported that managerial nursing staff have had the opportunity to express their views about the old system, prior to the change, and as such it could be argued that at least managerial nurses were able to somewhat shape the new approach to PA, first because the works agreement allowed for these changes to occur, secondly due to the new nursing director, and thirdly, because it was also supported by the WC and hospital management.

The next sections discuss the new system of PA using the three PA dimensions, i.e. the ‘why’, the ‘how’ and the consequences before using the framework for comparison to categorise both PA approaches.

#### 5.4.7 Why? Main purposes of team-days & team-related bonuses

##### *Nurturing team spirit through open communication*

The main purpose of team-days, according to those interviewed, is to strengthen and nurture the feeling of a team-spirit, as this has arguably been damaged during the period of individual-based evaluations, and thereby to improve team-work on the ward. Interviewees suggested that

the key purpose of fostering team-cohesion is possible by integrating the contributions of staff and enabling conflict resolution in a controlled setting. Participants were quick to compare team-based discussions with the previous system and to point out that the focus on teams rather than individuals is perceived as more constructive, particularly since the emphasis on evaluation of past performance is less prevalent and replaced by the purpose of collaborative discussions around potential future actions. Relatedly, an important reason attributed to holding 'team-days' was to create an atmosphere and framework within which an open communication exchange can occur. The opportunity to discuss a broad spectrum of topics and to express emotions was highlighted.

#### *Participative target-orientation*

Team-days have also been described as enabling participation regarding target-setting and implementation. General nurses reported that team-days enable them to get involved, participate and present their opinions about certain themes and even influence the types of goals that are, from their perspective, set together. In other words, reciprocal feedback was an aspect mentioned by participants, particularly regarding specific initiatives/goals that could be implemented on the ward. As ward managers use team-days to more or less subtly communicate their ward-related targets and to explain the reasoning behind them, thereby, it is argued, the team would be more committed to working towards achieving these goals.

#### *Improving work processes*

Interview participants suggested that a further purpose of team-days is to improve work processes in the long-term. From the point of view of the nursing directorate in particular, the function of team bonuses is to motivate and reward the team as a whole to improve team performance and encourage team-effort to achieve specific targets. As such, it is suggested that bonuses serve as a form of feedback and incentive for the team.

*it's more about how does one improve the quality at the ward, and that...everybody is steering in the same direction* (ward manager 1, NRW).

#### *Staff discussions*

In addition to team-days and associated purposes for conducting them, the restructuring of the PRB also envisaged the use of regular (development-orientated) staff discussions. The plan was that ward managers would be encouraged to (continue to) conduct individual appraisal however in the form of staff discussions, on a regular basis with all nurses. It was suggested that because previously individual discussions were predominantly used for performance evaluations and bonus determination, these appraisal discussions left little scope for other issues. Given that the

link between individual performance and bonuses would no longer exist, staff discussions were intended to become different in nature, i.e. with a focus on more qualitative feedback and around the personal development of staff and career planning.

#### 5.4.8 How?

##### Target agreement

There are several elements and processes surrounding the system of team-targets and bonuses. Before the actual team-days, team targets are agreed during target-agreement discussions between the nursing director and (nursing) managers, who are also responsible for communicating these goals further within their respective wards and organising the overall strategy in terms of how to reach goal-achievement. According to those interview participants involved in the target-agreement discussions at the upper management level, goals are not fully prescribed by the directorate but are mutually set. The deputy nursing director (2) described the general idea that within each division (e.g. consisting of three wards) each ward should have one common overarching goal alongside any other goals/targets. Having at least one goal in common was argued to serve to create “healthy competition” between the wards whilst working jointly towards this common goal across and within wards. Since the extent of eventual target achievement is linked to bonus payments, these targets are formulated in a measurable way. Depending on the extent to which targets have been achieved, each team member would receive the same bonus figure, including the respective divisional manager, ward manager and all general nurses. The main difference relates to the contractual status of the employee, i.e. a part-time employee would receive a slightly lower payment in comparison to a full-time nurse.

##### Nature of team-goals

A range of examples of team-targets were provided during interviews, including the implementation of electronic files on the ward or the reduction of overtime-hours. Yet another example of a team-target relates to the rotation of staff. That means that a certain number of employee rotations per year were agreed, which involves that nurses work on a different ward within their division for a specific period to facilitate co-working between these wards, eventually aiding the process of managing absences better. It was emphasised that targets must be objectively measurable, such as the minimisation of inventory, amount of pending annual leave of staff, or implementation of a student-guide-concept. It was further suggested that if during the review of target-achievement reasonable explanation is given by the respective manager regarding external reasons as to why the target could not have been achieved, then this would be taken into consideration in the determination of the percentage and bonus given.



It was also mentioned that different targets can be decided to be of different importance via a target-weighting, as also evident on the target-agreement form illustrated below.

**Figure 5.13: Target-agreement template at Hospital NRW**

<b>Division</b>								
<b>Surname</b>		<b>Name</b>		<b>Title</b>				
<b>Targets</b>		<b>2013</b>						
		Themes verbal	Weighting	Target-achievement in %	Milestone 1	Milestone 2	Milestone 3	Milestone 4
Financial targets	1.		0%	0%				
	2.		0%	0%				
	3.		0%	0%				
Process-oriented targets	1.							
	2.							
	3.							
Customer-oriented targets	1.		0%	0%				
	2.		0%	0%				
	3.							
Personal targets of the employee								
<b>Support requirements</b>								
Date: ..... ..... Signature: Supervisor					Notes			
..... Signature: Employee								

### Team-days

Team-days are designed to communicate targets, agreed during target-agreement discussions between managerial nursing staff, within the respective wards. Team-days take place for each ward twice a year and involve all nurses of each ward and take around 4 hours. During this time, the nursing team is substituted on the ward to enable each nursing staff of a ward to participate. Formal team-targets are set once a year and are usually communicated to the ward on the first team-day of the year, while the second team-day serves to check on the progress made and discuss any other current issues experienced by nurses.

It was reported that in advance of a team-day, staff can express their wishes regarding what topics should be discussed, which are collated on a sheet of paper. Apart from the target(s) agreed at the managerial level, additional goals can be set together at the team-level which relate to the themes raised by the team members themselves or steered by the ward manager. Thus, whilst there are targets concerning the whole division which are connected to the bonus, there is still considerable scope for ward managers to shape the structure of the team-day and incorporate suggestions from staff.

### *Staff discussions*

Lastly, regarding individual staff discussions, which were intended to occur alongside team-days, it was stated that there is no template or specific form which managers would have to use, although it would be typically documented that a staff discussion took place. The exact design of staff discussions is now within the scope of the managers to determine. In fact, ward managers cannot only decide how exactly to conduct their staff discussions but also whether to conduct them at all.

In sum, there are various elements to the PA system. Ward managers are still confronted with evaluations against targets, although these targets are set in a participative manner and concern the whole team, i.e. ward. For general nurses, the nature of PA has become more future-orientated with more room for discretion in goal-setting and involvement in how to reach certain goals. Comparison between individuals is no longer a key feature of PA. In the case of staff discussions, within-individual comparisons take place. Overall, the focus is now on development especially of the team as well as the individual.

### *5.4.9 Consequences*

#### *Lack of awareness of performance bonus*

The actual proceedings during team-days have been consistently described in similar ways by interview participants. However, particularly general nurses were not always completely clear in terms of the precise procedures and steps which precede the actual team-day and did not make a connection between target-agreements taking place at the managerial level and 'team-days' taking place at ward level. It also emerged that many in fact did not know, or were at least not aware, of the fact that PRBs are still paid, albeit based on team rather than individual achievements. Some were aware that they do not know all facts, while others were convinced that they either do not receive any bonuses, or that they receive these bonuses automatically and not based on performance. The reason for this unawareness might stem from communication issues and general confusion due to the frequency and complexity of changes. However, as the quote below eloquently demonstrates, ward or divisional managers themselves might design their team-days in a way that whilst they communicate team-targets to their teams, they consciously do not formally link it to bonuses. The reasoning behind it seems to relate to the desire to lessen the pressure on the team, rather than to prevent transparency.

*staff don't notice this pressure anymore because: the managers get goals, we project it onto our staff, of course. I think the employees themselves aren't consciously aware of it...So I think if one would ask my staff, they wouldn't even know which goals they'd have in order to*

*achieve this money...I never stated the goals that they need to achieve in order to get this money simply because for me personally, there is another sense behind it...I want that [they] are doing it anyway, because they are convinced of it and not because it's about the money.*  
[ward manager 1, NRW]

Many nurses also stated that whether or not they receive a bonus is not important to them and therefore no attention is paid to it, even if they happened to be aware of the team-bonus. Related to this is the overwhelming view that the amount of the performance-bonus was, and still is, in fact very small. Although participants often did not know the exact figure, it was suggested that the bonus would be in region of 200 to 400 Euro gross per year (assuming the full amount has been achieved), and between 0.5% and 1% of the nurses' annual salary. Nonetheless, most nurses expressed that the bonus itself would not have a significant impact on them as long as bonus payments are not differentiated between individual nurses anymore.

*I couldn't care less if I get something for it or not...* (General nurse 1, NRW)

*It's relatively little...I'm anyway not very interested in financial things* (educator, HCA)

#### *Team-spirit nurtured*

The main stated effect of team-days is the strengthened and nurtured team spirit, both in terms of the division and ward. Team-days were said to contribute toward improved cooperation between wards by pursuing a common goal but especially team cohesion and cooperation within the particular ward. This was often contrasted to the previous system entailing "condemning" individual evaluations which were argued to have had the opposite effect. General nurses described how team-days, instead, contribute to their own motivation and engagement within the team. Nurses identified a greater team effort to tackle specific tasks, which facilitates the work on the ward more generally. Nurses also emphasised that this current approach is more suited for the nursing occupation which inherently requires staff to work together. Those nurses who were aware of the 'team-bonus', also positively mentioned that it is no longer being differentiated between individual nurses. This "makes more sense" to them, however at the same time they "couldn't care less" about the bonus or are at least "not very interested" as long as it concerns the whole team.

*It really strengthens this team feeling and people help each other more..everybody is responsible for everything* (ward manager 5, NRW)

*I think it's brought us closer together* (General nurse, 1, NRW)

*This unity, team-dynamic develops* (ward manager 2, NRW)

The positive effect on the team is arguably reflected in the survey data, although it is based on a small sample (n=26). Regarding the statement 'Team members have to communicate closely

with each other to achieve the team's objectives', 20 percent strongly agreed, 76 percent agreed, and just 4 percent disagreed, albeit strongly. Regarding the statement 'Team members have a set of shared objectives' (n=25), the majority agreed: 28 percent agreed strongly, 26 percent agreed, 4 percent neither/nor agreed but 4 percent strongly disagreed. However, at the time of the survey, the new team-based system was only in place for about a year, which might explain those disagreeing responses.

#### *Communication & feeling taken seriously*

The manner in which team-days are conducted was said to have improved communication drastically and made information exchange more efficient. Participants highlighted the nature of open discussions during team-days and the fact that they get the chance to voice their opinion. Team-days are said to provide the scope to talk in more detail about the reasoning behind certain initiatives in a relaxed environment. This was argued to contribute not only to a better understanding but also generally has been related to increased team-satisfaction. As team-days provide an opportunity to discuss a range of issues, "let off steam" and get involved, nurses feel taken more seriously as a result as well.

#### *Participation & feeling of ownership*

Related to open communication is the involvement of nurses in team-discussions, the incorporation of their views and the resulting perception of participation. This is the case although certain team-targets (those subject to evaluation bonuses) would have been agreed beforehand. Team-days still provide the scope for nurses to decide the implementation strategy of these targets and the creation of additional goals. The fact that targets are discussed in depth was said to enable staff to accept and take ownership of goals which, in turn, leads to a smoother and more efficient implementation and target-achievement. General nurses expressed that this participative manner is greatly valued. The fact that they are encouraged to get involved allows them to feel as though they can influence their own work and co-design goals and their implementation.

*that one can involve everybody...and also this co-decision and this having a say and then also to participate...That's motivational. (General Nurse 7, NRW)*

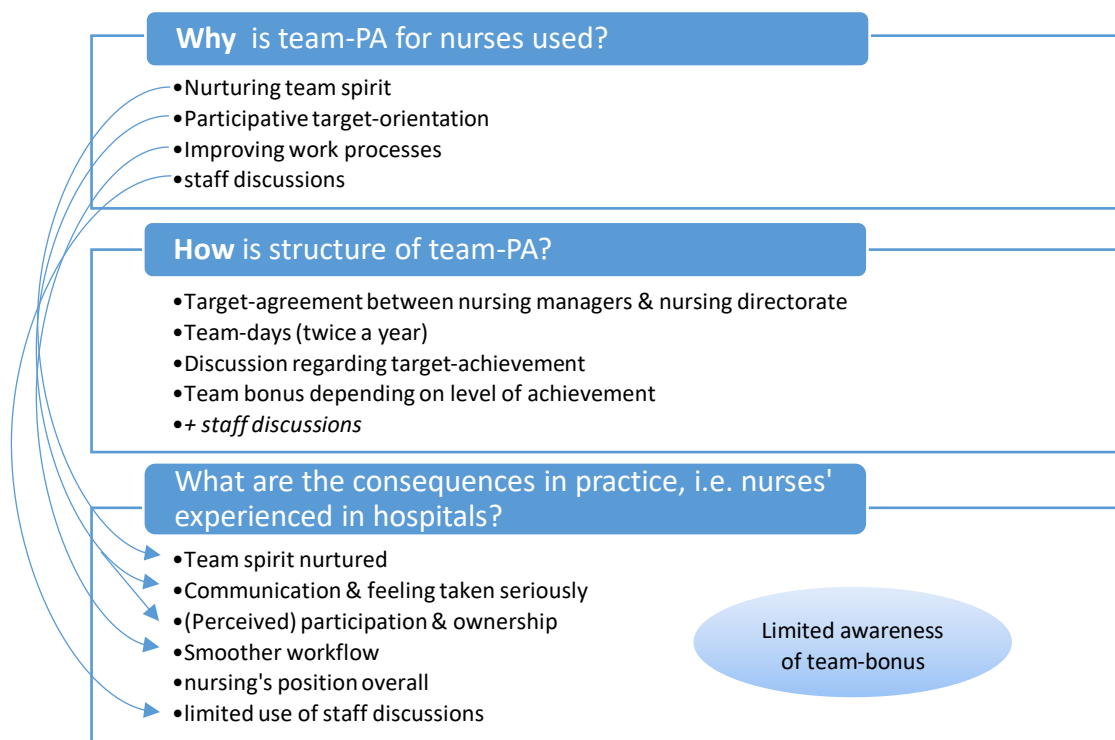
#### *Improved work processes*

Connected to the previous point, it was suggested that ultimately team-days improve work performance in general, and makes work processes smoother. This is because not only do team-days enhance team-work but they enable the clarification of any uncertainties regarding work itself. Through the participation of the whole team, ideas in relation to the improvement of

certain processes might also contribute to a more efficient workflow. Ward managers also described how they can use team-days to allocate certain tasks more efficiently, yet again with the involvement of their staff, who (due to their participation) are more motivated to take responsibility for these tasks.

*one can clarify everything...we work in a more consistent manner..[and] more uniformly*  
(General nurse, 1, NRW)

**Figure 5.14: PA at Hospital NRW according to dimensions of PA (team-based)**



### *Nursing as a whole*

Furthermore, based on the interviews it could be argued that as nursing teams are strengthened, this in turn strengthens nursing's position overall at this hospital. As a general nurse (General nurse 6) mentioned, strategies can be discussed, for instance, in terms of how nurses should handle requests of doctors to carry out certain tasks or how to deal with other occupational groups. This enables each team and the division as a whole to display a united front, pursuing a common strategy.

### *Staff discussions*

Finally, while staff discussions might be encouraged by the nursing directorate, these are not mandatory and it was stated by managerial staff that it is not checked whether they are conducted. Thus, staff discussions were not a top priority. Most said that they prefer to conduct

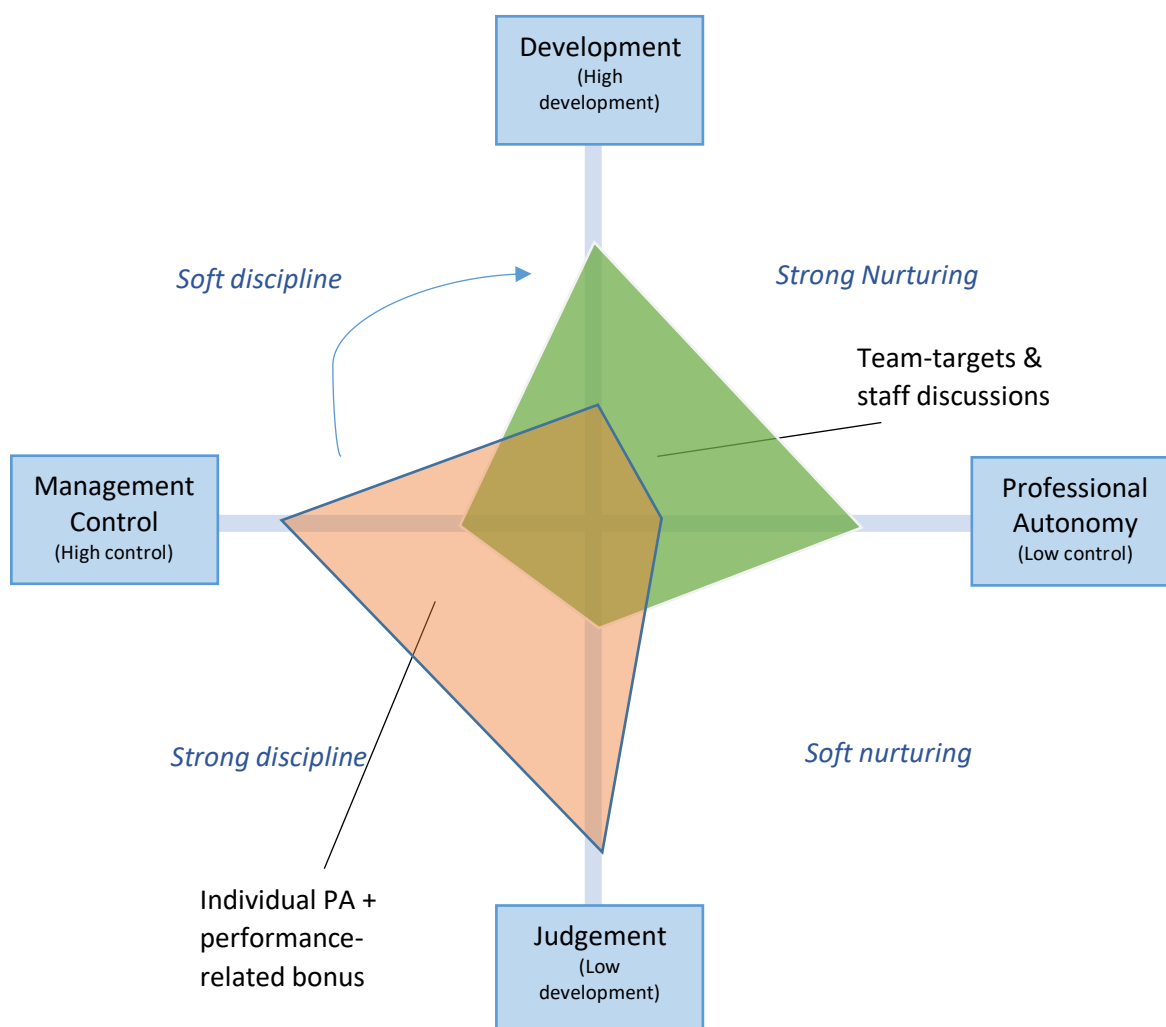
discussions with staff, rather than 'staff discussions' per se, on an as-needed basis, focusing on the specific trigger that gave rise to the need to talk. Often more formal/regular staff discussions are considered unnecessary, especially at wards where nurses' organisational tenure has been long. Moreover, given that team-days are extensive and provide the opportunity to discuss most issues, individual staff discussions are not perceived to add much. The fact that staff discussions are not consistently conducted on wards since the abolition of the individual performance bonus, was echoed in interviews conducted with general nurses. Survey results confirmed this. Although based on a small sample (n=26), of those participants who completed the survey, 54 percent indicated that they did not have an appraisal, annual review or development review in the last 12 months. Likewise, of those general nurses interviewed only a few nurses reported to have had a staff discussion at some stage recently,

However, few divisional/ward managers confirmed that in general, staff discussions are an important motivational instrument and used on their ward more regularly. In those cases, it was positively mentioned that because staff discussions are no longer concerned with the distribution of PRBs, managers are now more flexible in terms of the timing of staff discussions. Those nurses who have had a recent experience with a staff discussion expressed that they valued it in addition to team-days. During the staff discussion itself, it was reported that the superior would discuss the current situation with the nurse regarding e.g. their concerns, wishes and plans for the future. Hence, one element would be a discussion around the personal development of the nurse (further training) or other goals for the future. Secondly, general feedback would be provided during such sessions. Staff can also contribute to the discussion and raise issues or ideas, as was recalled by one interviewee who was able to make suggestions in terms of processes and structures on the ward. Overall, in those cases where staff discussions are conducted, they are generally positively received, which is also reflected in the survey data, despite the small sample (n=12): 67 percent stated that PA helped them improve their job, 75 percent that it helped them agree clear objectives for their work, and 64 percent (n=11;1 missing) that it left them feeling like their work is valued by their organisation.

#### 5.4.10 Summary and conclusion

Based on the findings of the fieldwork, scoring was conducted on the diagram (i.e. framework for comparison). Again, the first stage involved to analyse each hospital case by comparing the four main dimensions and sub-dimensions (provided in table 2.4) within the particular case. The case of hospital NRW can be suggested to constitute two versions of PA, before and after changes to the system occurred. These two PA systems have been analysed separately and were then, at the second stage of analysis, compared across the other hospital cases on each dimension to guarantee consistency across cases. Taking into consideration the framework for comparison, it can be concluded that appraisal at this hospital shifted significantly from a PA system characterised by 'judgement' and strongly perceived attempts of 'management control' and discipline to an approach geared towards the nurturing and development of the team, with more scope provided for discretion and autonomy, as shown below using the illustrative framework. In addition to this team-orientated system, individual staff discussions are also held, although not consistently. In those reported cases where staff discussions have been experienced recently, they were similarly described as predominantly developmental and nurturing in nature, with a focus on the individual nurse.

**Figure 5.15: Framework for comparison: Hospital NRW**



Source: Author's own compilation

In terms of the former approach, the concentration on judgement is evident in the appraisal form, which clearly sets out the 'systematic performance evaluation' of nurses on a points-based system. The perceived judgemental, disciplinary approach and feelings of monitoring and control were also reported during interviews. Many nurses conveyed that they felt offended by the system, and that it had little to offer them in terms of their personal development or otherwise. Having said that, even when Hospital NRW still practiced 'systematic performance evaluations' linked to individual PRBs, further training was one element in the appraisal form and as such at least one consideration. However, it was not regarded as conducive for promoting or managing these aspects and, at least partly for these reasons, the hospital envisages that nurses' personal development and further training will now instead be focused on during



individual staff discussions, similarly as in Hospital RP. Whilst it was recognised that nurses' commitment was envisaged through this individual-based system, it had a demotivational effect on them, as variations in bonuses paid created resentment within the team. The system as a whole emerged as inefficient due to the timing of evaluations to higher managerial staff and, when it involved the setting of individual targets, the setting of meaningful targets emerged as a challenge. Overall, nurses perceived the process as inherently unfair and welcomed the abolition of the system.

These findings resonate with the PA literature which suggests that control/discipline-orientated approaches to PA are not appropriate for occupations like nursing (Northcott, 1997). Nursing managers felt largely uncomfortable to assess their staff using the points-based system on which bonuses depend, in line with suggestions in the literature that appraisers despise having to "play God" (McGregor, 1957; Grint, 1993). Research on PA further suggests that "resentment, resistance and alienation will occur" (Simmons and Eades, 2004, p. 155) when PA is largely top-down, associated with monitoring, surveillance, discipline and control. And indeed, resentment and even alienation was identified under this type of PA. While no active resistance was discernible, passive resistance or as termed by Healy (1997) 'appraisal disdain' occurred in the sense that general nurses only grudgingly accepted the system, would not actively engage with the process and only treated PA like a necessary evil and a formality. Hence, this form of PA led to a range of unintended consequences which is in accordance with previous research which has noted the "perverse effects (...) when employees are encouraged to compete rather than cooperate" (Perkins et al., 2016, p.190).

The current team-orientated approach is favoured because it is regarded as more efficient and in sync with the nature of the work which requires team-work and collaboration (Ang et al., 2013; West et al., 2002). General nurses spoke highly of team-days during which they willingly participate and of the positive knock-on effects it has for the team and for individual nurses as well. A surprising finding was that whilst bonus payments still exist based on team performances, even those who were aware "couldn't care less" (General nurse 1, NRW) about this feature, so long as payments are not differentiated between individuals. This view is linked to the low amount of the bonus, but also to more value being placed on other elements, such as the impact on team development and the scope PA provides to integrate oneself and one's own ideas. This reaction is thus that of a cohesive group. Staff discussions, when conducted, are seen as conducive for personal development and feedback. However, as ward managers and

general nurses have become disillusioned with the system of individual PA discussions previously, many chose not to conduct them for now.

Reflecting on the external drivers, i.e. the national institutions and how they contributed to the respective approaches to PA taken at this hospital, the following conclusions can be made. The initial driver related to changes to the TVöD which provided the scope for a bonus system for the first time. The CEO's role in an employer association, involved in bargaining negotiations, might have contributed to the employers' initiative to seek to implement such a system. However, as in hospital RP, it was only possible to implement PA, including the one linked to individual bonuses, in cooperation with the WC. The WC in turn was informed by the wider context and generic pressures, such as hospital privatisation trends, which compelled the WC to cooperate. The move to the team-orientated system plus individual staff discussions was due to unintended consequences that transpired, mainly in relation to the inefficiency of the former system, and coincided with the arrival of a new nursing director who, together with the WC, supported this transformation. With the new system of PA, nursing managers now have more scope to shape appraisal during team-days. Despite bonuses being depended on team performance, nursing managers often chose to not make a concrete link between targets and team-bonuses in an effort to lessen pressure, as it is regarded as more important to focus on the team development aspects and retain individual nurses given current nursing shortages.

## 5.5 Conclusion

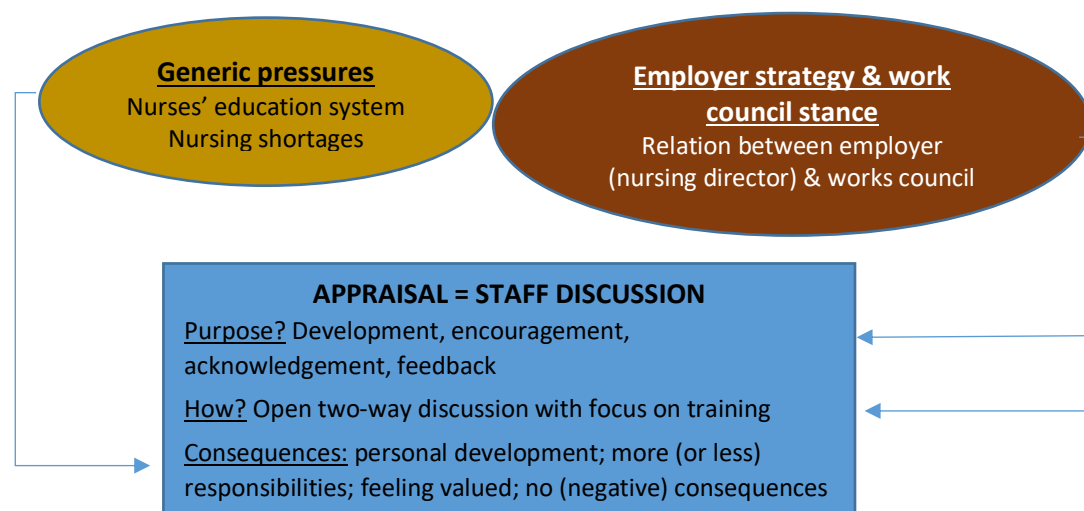
To identify if and which broader contextual factors contribute to the specific approaches to PA taken in German public hospitals, this chapter began by exploring the wider national context (section 5.1), including the general hospital environment and pressures, the specificities of the employment relations system, and the current status of nursing. Germany's hospital context was confirmed to be characterised by pressures for performance both in terms of efficiency and quality. This is connected to developments such as in relation to privatisation trends and financial pressures. Another challenge is the significant nursing shortage experienced in the country. This aspect relates, at least in part, to the status and 'attractiveness' of the nursing occupation or lack thereof. Taking into account the role of education, regulation and professional organisations, the 'strength' of the nursing profession can be concluded to be such that nursing institutions do not engage with or have limited scope to be able to directly influence PA practices. Instead, the most relevant institution in the German case regarding PA is the employment relations system, specifically the WC, as highlighted by the VoC framework. The role of the WC is particularly relevant due to the absence of a strong voice within nursing for which it compensates to a degree. Relatedly, works council-employer relations play a role regarding the approach to PA. WCs and their relations with employers and respective strategies may differ (Greer et al., 2010; Jirjahn et al., 2011; Kotthoff, 2013; Marsden, 2015). Therefore, the German case exhibits some within-country variations in relation to PA, despite a clear tendency.

As described in section 5.2, in general, it emerged that one can broadly differentiate between three types of PA in the German hospital sector, namely staff discussions, target agreement (discussions) and PA systems linked to PRBs. Formal target agreements are usually conducted at the higher managerial level within nursing. Regarding general nurses, WCs tend to resist more discipline-orientated approaches, especially those related to bonuses, while being supportive or at least neutral towards development-orientated approaches usually in the form of staff discussion. The use of PA can be observed to have increased in the context of wider hospital pressures. Yet, as indicated, there is scope for difference as WCs may respond in different ways.

Section 5.3 onwards was concerned with the detailed examination of PA at two German hospitals. Hospital 'Rheinland-Pfalz' (RP) adopts the most common type of appraisal in German public hospitals in the form of nurturing staff discussions and is thus illustrative of the German case. At hospital RP, there was a general awareness that the WC would resist other formats of appraisal. Apart from the employer's strategy and its relation with the WC, the wider contextual

background of nursing shortages and a lack of new nursing recruits contributed to the focus on this nurturing appraisal type in an effort to increase retention. The vocational system of nurses in Germany was furthermore highlighted as a driver for a development-orientated appraisal, since “up-skilling” is required. This is illustrated by the oval text boxes in figure 5.16 which represent the wider national context in terms of generic pressures on the one hand and the role of the WC on the other, which influence PA at local level regarding the ‘why, ‘how’ and consequences. Due to these drivers, the core purpose of PA at this hospital is the personal development of individual nurses. The appraisal form provides the necessary scope and freedom to gear the staff discussion towards the needs of the individual nurse. Consequently, staff at this hospital feels generally valued, as also indicated in the survey results.

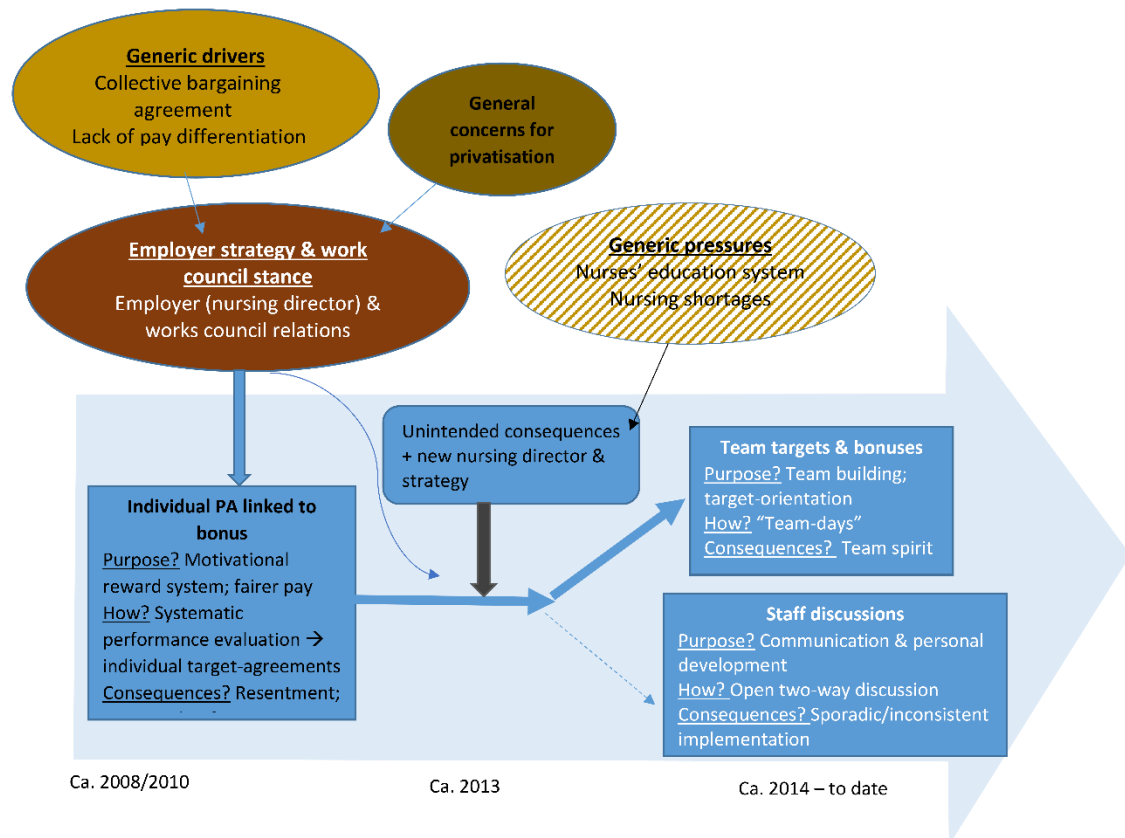
**Figure 5.16: National contextual factors and their impact on PA at Hospital RP**



The second German hospital ‘NRW’ provides a rare, exceptional example of a public-sector hospital which has implemented but later abolished individual-based evaluations linked to PRB payments. The initial driver for implementing PA linked to individual PRBs related to changes in the TVöD. However, the introduction of this system was only possible due to the cooperative stance of the particular WC, which in turn was informed by the wider economic context of hospitals and general fears of privatisation. The purpose of individual PRBs mainly related to the motivational potential of these rewards but also generally improved individual performance. PA constituted the evaluation of prescribed criteria before shifting to individual target agreements in later stages and the evaluation of target achievement. The intended purposes did not match with the actual outcomes. Instead of improved performance and increased motivation, the system proved inefficient and caused dissatisfaction. Although general nurses and nursing

managers alike were highly discontent with this system, no active resistance could be discerned. However, passive resistance was traceable in the form of unwilling compliance.

**Figure 5.17 National contextual factors and their impact on PA at Hospital NRW**



Mainly due to these unintended consequences, the new nursing director with the support of the WC, significantly altered the system and refocused it on teams alongside the option to conduct individual staff discussions. There was also a realisation that given the state of the education system for nurses and nursing shortages, it is more important to focus on development and retention. Since the implementation of these changes, this hospital case now resembles the 'typical' case more given its focus on development albeit with a focus on the team. In terms of the new team-orientated PA system as well as staff discussions which now occur sporadically, nurses expressed that they are satisfied and perceive this as a nurturing experience. Figure 5.17 seeks to illustrate these developments at Hospital NRW. It shows that generic national drivers existed in terms of collective bargaining provisions and concerns for privatisation which influenced the WC and the employer and their decision to pursue individual PA linked to PRBs. However, unintended consequences in conjunction with national pressures relating to nursing shortages and the arrival of a new nursing director lead to a change in the system and PA's character.

## Chapter 6: Findings: Czech Republic

### 6. Introduction

This chapter presents the findings of the Czech case by drawing on 'national-level' and workplace-level interviews, survey data and documentary evidence in consideration of the literature reviewed in previous chapters. It is divided into three main sections. Section 6.1 deals with the broader hospital and national institutional context. It firstly explores the general hospital environment as well as hospitals' systems for quality assurance. Then it focuses on the Czech employment relations system including collective bargaining and local workforce representation. Subsequently, the status of nursing is addressed.

Section 6.2 introduces the main type of PA and its prevalence in the Czech hospital sector. Hospitals in the Czech Republic were found to either have no formal, structured PA systems in place or, alternatively, tend to adopt PA in the form of performance evaluations to comply with hospital accreditation norms and guidelines, a theme which is further explored in section 6.3.

Section (6.3) is concerned with the detailed exploration of PA in two Czech hospitals, including regarding how the wider national context and specific institutional factors have influenced 1.) the purpose of PA 2.) what form PA takes, and 3.) the consequences of PA in practice.

## 6.1 Hospital & national institutional context: Czech Republic

### 6.1.1 Overall hospital context & pressures

#### *Pressures for efficiency: hospital reduction, competition, financing and nursing shortages*

The Czech Republic is a country still considered 'in transition', although there has been extensive reform in the public sector since the fall of communism and velvet revolution in 1989. Indeed, today the Czech Republic is "one of the most developed economies among the post-communist European Union Member States" (Alexa et al., 2015, p. xix). As according to interviews conducted, the accession to the EU in 2004 was a further important driver that resulted in changes at the political and economic level and the legal sphere.

In healthcare, the most drastic change relates to the transformation of a Semashko healthcare system, i.e. a "Soviet-type NHS system" (Roubal and Hroboň, 2011, p. 100), to one based on a system of social health insurance contributions. This was accompanied by a wide-scale privatisation process of public hospitals in the 1990s (Schlanger, 2003; Nemec et al., 2015; Kahancová and Martišková, 2016). A further noteworthy important change relates to the decentralisation process in 2003, when 14 regional governments were created and many of the previously state-owned, non-privatised hospitals have been transferred to either the regions or municipalities (Alexa et al., 2015; Roubal and Hrobon, 2011; 2013; Kahancová and Martišková, 2016). In the aftermath of this, some regional hospitals have changed their legal form to joint stock companies, although many have continued to be fully or partially owned (i.e. as a majority shareholder) by regional authorities. While it is argued that a change in a hospital's legal status in itself is not associated with significant changes to hospital governance or performance (Alexa et al., 2015; Roubal and Hrobon, 2011; 2013; Pirozek et al., 2015), it represents 'formal privatisation' (Glassner et al., 2015). In terms of ownership, the current Czech hospital environment is such that private hospitals make up approximately one third of hospitals, another third is in regional ownership and another third is divided into hospitals in municipal and state ownership (Kaminska and Kahancova, 2017).

Despite many advancements, the current healthcare system is argued to be financially unsustainable. The vulnerable financial situation is argued to have been exacerbated by the economic crisis (e.g. Alexa et al., 2015), as also emerged during interviews. Despite a lack of a clear agreement amongst politicians in terms of reform paths, there are suggestions that further reforms have implied the privatisation of hospitals (Votápková and Šťastná, 2013; Papouschek and Böhlke, 2008), with the Czech government using the 2008-2009 financial crisis and

inefficiency concerns to argue for further wide-reaching reforms, including further hospital privatisation (Dittrich and Stara, 2011; Votápková and Šťastná, 2013).

Further pressures, which are argued to make cost-containment measures and reforms necessary due to strains on healthcare expenditure, include the ageing population as well as technological changes (Dittrich and Stara, 2013; 2014). Demographic changes are associated with increased demand, due to more elderly patients with more complex health problems, as well as an ageing healthcare workforce which contributes to shortages of nurses and physicians. Indeed, all interviewees highlighted the acute nursing shortage in the country. The lack of nurses means that *“some hospitals even had to close some units”* (Interview 3). The nursing shortage is attributed to several factors. Firstly, as indicated, demographic developments as low birth rates in the past means that there are less people and graduates who enter the occupation. Secondly, many nurses emigrate to neighbouring countries like Austria, Germany, or the UK, predominantly for better pay conditions. Thirdly, some attribute changes to the education system of nurses at least in part to the current shortage. Lastly, the nursing shortage was argued to be connected to the overall status of nursing – or rather a lack thereof (see section 6.1.3).

What particularly emerged in the Czech case and interviews conducted is hospitals’ concerns of potential hospital or ward closures, bed reductions or hospital mergers. This especially pertains to municipal or smaller regional hospitals. These fears exist amidst a changing hospital landscape. According to the trade union CMKOS: *“Between 2008 and 2015 a total of 14,720 hospital beds have ‘disappeared’”* (Chválová, 2016). This bed reduction was in accordance with the intentions of the Health Minister and is expected to continue. This is broadly in line with other news reports of (planned) hospital mergers and closures (e.g. Lazarová, 2013; Johnstone, 2017) as well as Eurostat data (see below), which indicates sharp reductions in the number of hospital beds in both public and not-for-profit hospitals between 2008 to 2014, while the number of private (for profit) hospitals has increased. In total however, there has been a stark and continuing reduction in the number of hospital beds in the Czech Republic of 9.3 percent between 2008 and 2014.



Table 6.1: Hospital beds by ownership in the Czech Republic (and Germany) 2008-2014		2008	2010	2012	2014	% change 2008-14
Public ownership	Czech Republic	66412	:	59003	57566	-13.3
	Germany	275390	273789	270813	271079	-1.6
Not-for-profit private ownership	Czech Republic	465	:	336	282	-39.4
	Germany	204763	200672	198412	195052	-4.7
For-profit private ownership	Czech Republic	8047	:	10675	10089	+25.4
	Germany	194267	200012	201218	200206	+3.1
<b>Total</b>	Czech Republic	74924		70014	67937	-9.3
	Germany	674420	674473	670443	666337	-1.2

Source: Eurostat, available at: [http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare\\_resource\\_statistics\\_-\\_beds](http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_resource_statistics_-_beds)

These developments have resulted in hospital competition which, again, particularly concerns hospitals in the regions and municipalities outside the capital (Votápková and Šťastná, 2013), and hospitals not directly owned by the state, as reported during interviews. Generally, smaller municipal or regional hospitals tend to be under more pressure, have less financial aid and e.g. less healthcare staff in place per patient (e.g. Interview 6). Fears of ward or hospital closures amid significant reductions in the number of beds exists here as well.

*there are large differences in..conditions..between..small hospitals and e.g. the military [i.e. state-owned] hospital...* (Head Nurse; chairman at CAS)

Moreover, many interviewees raised the uncertainty surrounding possible changes in the way in which health insurance companies reimburse hospitals. Since 2007, in an effort to increase efficiency, hospitals are increasingly paid on the basis of the DRG system in combination with individual contracts and global budgets (Alexa et al., 2015), with DRGs being the main payment mechanism for hospitals since 2012 (Alexa et al., 2015; Malý, 2015). However, due to remaining cost-inefficiencies and a lack of transparency, the 'DRG Restart' project was initiated in 2014/2015. This implies the re-design of the DRG system with a full transition to DRG-based contracts likely to occur gradually (Haffner et al., 2016). The overall aim is to create "a more transparent, effective and fairer hospital care reimbursement system" (Malý, 2015, p. 3). A further point of uncertainty particularly highlighted in interviews relates to the issue of 'quality management' and external quality assurance, further discussed next, as health insurance companies will potentially pay hospitals more in the future if they have external accreditation.

### *Pressures for quality: Quality management systems*

Alongside fiscal challenges and pressures for efficiency in the Czech hospital sector, an increased quality orientation is apparent in the drive for hospital accreditations. Pressures for the external assurance of quality have risen since the 1990s following the end of communism. Since then, organisations from various industries including healthcare have begun to concern themselves with quality management and the issue of certification and/or accreditation. Initially, the Czech Republic was highly influenced by American systems of quality assurance. General pressures to comply with EU regulations have further influenced the field of healthcare and intensified the need to comply with certain standards.

*After the revolution in 1989 we looked how we can formulate and warrant standards for the healthcare system...we've worked hard to improve this, and we're constantly improving our standards for hospitals (Co-founder & Chairman of Board of directors & auditor of "United Accreditation Commission" (SAK))*

As established before, it can be mainly distinguished between two different types of external quality assurance: certification and accreditation. The relevant Czech accreditation standards were specifically developed for the healthcare context and are therefore regarded as being of a higher level and more 'practice-orientated' than so-called ISO certification norms. Moreover, whilst a hospital would have several different ISO certificates for different areas (e.g. management, finance, or certain hospital units), accreditation usually concerns the whole hospital. Interview participants suggested that the systems of accreditation have evolved and new organisations providing certification/accreditation services have emerged, but the main (and 'traditional') accreditation body continues to be SAK CR (Spojená Akreditační Komise – Czech Republic). This is in line with Shaw et al. (2010b) who suggest that the most commonly used 'certification standards' are ISO 9001 and the main accreditation organisation in the Czech hospital sector, which has its own standards, is SAK (CR).

For the most part, hospital certification/accreditation is a voluntary process, except for certain areas at the hospital (e.g. laboratories), which seeks to ensure and attest adequate levels of quality. Yet, many hospitals undergo such processes on a voluntary basis and increasingly so (Somrová and Bártlová, 2012) for several reasons. Firstly, interviewees suggested that it is a matter of prestige for hospitals. Particularly as more and more hospitals engage with these processes, remaining un-accredited hospitals are under pressure to catch-up. Whilst it was stated that it is not the case yet that patients choose hospitals based on their respective certificates, it was predicted that 'it will come' (Interview 5: Co-founder, Chairman and auditor of SAK). Secondly, as the quote below indicates, there is an expectation that accredited hospitals

will, in the future, be better paid by the health insurance companies. There are already reports that un-accredited hospitals are being financially disadvantaged.

*For years, we've been fighting with the health insurance companies to motivate hospitals to become accredited..That the insurance company e.g. provides 1% more rewards for treatments in the accredited hospital. However rather the reverse is possible, the non-accredited get less... (Co-founder, Chairman and auditor of SAK)*

Thirdly, interviewees expressed that hospitals seek to protect themselves with such certificates from potential closures (ward or hospital closures/bed reductions). Certainly, as most hospitals are now accredited, those hospitals without accreditation are perceived to be more under such threat. Finally, hospitals may seek accreditation to improve their own processes and ultimately quality and efficiency. Even if hospitals are not formally accredited, since the accreditation standards are publicly available, management might still implement these standards to improve work processes and “get their hospitals in order” (Interview 5: Co-founder, Chairman and auditor of SAK).

Overall, the perceived need to undergo such processes is arguably fuelled by a level of uncertainty about what the consequences may be in the future, in relation to e.g. extra payments from the health insurance companies or protection from potential bed/ward/hospital closures. Since hospitals increasingly engage in accreditation processes, there is considerable pressure on the remaining ones to acquire accreditation due to hospital competition.

Importantly, in the Czech case hospital accreditation was consistently argued to be *the* key impetus for the adopting staff appraisal in hospitals, as associated guidelines require PA. Indeed, participants were quick to raise the issue of certification/accreditation when asked about the reason for appraisal, as these illustrative quotes show.

*It [PA] is only done because of accreditation...[PA] is merely done to ensure that the organisation is accredited...before that...it has never happened anywhere. (Professional and trade union for healthcare workers)*

*It's usually introduced when the hospital prepares for accreditation. Because it's required there...by the accreditation companies. It's part of the process. (Czech Association of Nurses (CAS))*

*accreditation was the engine, that one introduced [PA]...before it was never dealt with. (Head nurse, former presidium member of CAS)*

In sum, while the Czech Republic is still considered a transitional country, much reform has occurred since the velvet revolution. Legislative and structural changes were further accelerated with the accession to the EU. While the field of healthcare was subject to much adaptation, it is

considered financially unsustainable and deemed in need of further reform (e.g. Alexa et al., 2015; Veverkova, 2011). The current hospital landscape is characterised by hospital competition, a general trend of hospital bed reductions, and privatisation. Hence, pressures for organisational performance in terms of economic efficiency are certainly apparent in the Czech case. These wider hospital pressures have also an impact on the perceived need for hospital accreditation, which has direct implications for the use of PA. As Czech hospitals face competition and fears of bed or even hospital closures, hospitals seek to protect themselves by having accreditation. Furthermore, since the financial context is challenging, and hospitals are already financially disadvantaged if not accredited and likely reimbursed more favourably in the future by having accreditation, the overall hospital context is an important driver for this trend. The following section explores the role of employment relations institutions, followed by the exploration of the current situation of nursing in the country. It will be shown that the role of such employment relations and nursing institutions is limited and therefore wider trends (specifically regarding hospital accreditation and PA) are not within their realm of influence.

### 6.1.2 Employment Relations Institutions

#### *Collective bargaining arrangement*

As there is no higher-level collective agreement in the Czech healthcare sector, collective agreements can only be concluded at the organisational/hospital level (Kaminska and Kahancova, 2017). According to interviewees, a collective agreement negotiated between the local trade union and the hospital's management is usually valid for four years. Whilst additional benefits can be negotiated at hospital level, the scope of collective bargaining is restricted, because the government effectively sets out pay and other key terms and conditions for the public-sector workforce in accordance with the Labour Code and thus any agreements are set within clear legal parameters (ECOTEC, 2006; Veverkova, 2011; Alexa et al., 2015). Consequently, organisational-level agreements tend to focus on limited areas such as overtime work and benefits such as luncheon vouchers (Veverkova, 2011). The rather limited role of trade unions and limited scope of collective agreements at local level has also been highlighted during interviews, as the quotes below illustrate.

*Every year there are negotiations between the management and...the trade unionists want e.g. more holidays...some sick days, or some benefits for employees...but they aren't overly strong. It's rather in a friendly manner...* (Head Nurse; chairman at CAS)

*Trade union organisations...mainly...try to negotiate some advantages for nurses..including ....in terms of holidays/annual leave and holiday allowance, to care for children and so on...* (Professional and trade union for healthcare workers)

*Mostly it's about working hours, holidays/annual leave, discounts for lunch in the canteen,... they don't [have influence over adoption of PA] (Co-founder, Chairman and auditor of SAK)*

Management practices such as appraisal were said to not be within the realm of collective agreements. Furthermore, decisions around hospital accreditation does also not involve the trade union. As discussed in the next section, WCs also play an overall limited role and are likewise not involved in the negotiation of these or other matters. Interviewees suggested that hospital-level negotiation is further constrained by the financial context of hospitals, particularly those which are not directly funded by the state, i.e. regional or municipal hospitals. If the economic situation of the hospital is such that it cannot provide e.g. bonuses or other financial rewards, then the room for negotiation is further confined.

*The bargaining position of trade unions is dependent upon the financial situation of those hospitals. The best negotiation situation is in state hospitals, where they are paid directly from the budget of the Ministry of Health (Professional and trade union for healthcare workers)*

As will be presented in the Czech hospital cases of this study, in terms of funding, the bonus is funded at local level by the hospitals and the bonus amount depends on the financial performance of the hospital in a given year. There is no formal hospital-wide system for controlling costs in place, as each ward and division receive their proportion of the bonus, which is then under the discretion of the respective manager to distribute.

Due to this general set-up, systems for the distribution of PRBs are also less regulated in the Czech Republic. This is in line with reports that in the Czech Health and Social Services, bonuses and other discretionary and/or performance-related pay components lack regulation by law and thus precise guidelines in relation to the application of such systems (EPSU, 2017). Similarly, according to Saltman et al. (2011, p. 61) who refer to Czech public sector hospitals state: "(...) in Czech public contributory organizations (...) the basic salary level is set by governmental decree, but the hospital can allocate bonuses". This, in turn, provides more scope for variation in the way in which e.g. bonus systems are implemented and the misuse of such systems, as will become apparent in the discussion of the hospital cases.

*This [linking appraisal to pay], I think, this should certainly be a part of PA...but as long as this system isn't set up like this, then...it depends on who knows who well [favouritism]...it doesn't work for now... (Professional and trade union for healthcare workers)*

As the quote above indicates, a well-known fact, although not widely reported at least in the English-speaking literature, is that bonus systems for healthcare workers are typically not set up

in a systematic way and instead are distributed in an unsystematic ad-hoc manner, often based on favouritism. One exception is Hedija (2016) who in her research looks at the gender pay gap of individual units in a Czech hospital, taking a quantitative approach. Although (basic) wages in the Czech public sector are regulated by government regulation, regulation in terms of bonuses is lacking, and thus Hedija (2016) finds that there were no internal regulations in place at the hospital. Consequently, this implies that “an employee's actual gross wage, including bonuses, depends on the bonuses granted by the head of department, who is solely limited in their allocation by the size of budget available in that department. (...) heads of department have relative flexibility in wage formation” (Hedija, 2016, p.127). In other words, if bonuses are provided at hospitals, the way in which they are allocated may indeed vary from unit to unit. Hence, in the Czech case, a local and ad-hoc nature of these bonus initiatives can be identified.

#### *Employee representation at local level*

The option to form a WC was only introduced in the Czech Republic in 2001 (Funk and Lesch, 2002; Jevtic, 2012). According to Funk and Lesch (2002), while Germany adopts a system wherein WCs co-exist with trade unions (dual representation), the Czech system originally implied a competing system as it was not possible to establish a WC if there was a local trade union present or a collective agreement in place (e.g. Jevtic, 2012). However, this legislation was deemed unconstitutional in 2008 (Fulton, 2015) and since, but only since, then it is possible to have a union and WC in place at the same time.

However, in practice it is very likely that Czech organisations more generally have neither a WC nor an active local union at all. According to interviewees, as well as Gürlich and Benasova (2016), employers are not obliged to set-up a WC, and in many cases they do not materialise. Instead, interviewees suggested that the nature of the WC in the Czech Republic is that of a voluntary committee and those employees who are engaged with it work on a voluntary basis for this committee. Again, the dominant Labour Code regulates the rights of trade unions and WCs and stipulates that the latter should be consulted and informed about certain facts (Baccaro and Heeb, 2011; Gürlich and Benasova, 2016). Czech WCs “only act as a mediator between the employers and their employees, in order to ease the flow of information and consultation” (Youngmo, 2011). Thus, the role of the WC is highly limited and does not extend beyond these consultation/information rights. Czech WCs have no co-determination rights and have a subsidiary status to trade unions and hence a “rather narrow scope” (Jevtic, 2012, p.58). The notion that ‘WCs’ do not play an important role was reflected throughout the interviews conducted.

*That's laid down in the Labour Code that something like this [WC] can be, but I don't know any hospital where something like that would work, that there would be a WC. Practically, it does not exist...[WCs] don't play a big role no no no.*(Professional and trade union for healthcare workers)

In fact, neither WCs nor local trade unions have co-determination rights but only consultation or information rights regarding issues such as mass dismissals, health and safety, and company restructuring (Funk and Lesch, 2004; Fulton, 2015). There are some differences regarding the scope of information and consultation rights between the unions and WCs, however in terms of PA the local trade union only has the right to be informed (see Fulton, 2015). Overall therefore, there is considerably less scope in the Czech Republic for an employee representative body to influence the adoption or form of PA.

### 6.1.3 Nursing in the Czech Republic

#### *Nurses' status*

The fact that only in 1989 the Velvet Revolution ended more than forty years of communist rule in Czechoslovakia is an important aspect, and its influence needs to be appropriately accounted for in any analysis of nursing, given the “historical neglect of nursing and midwifery” (Salvage, 1997, p.2) in the region. As Matoušová and Tollarová (2014) suggest, despite important and radical changes within the Czech healthcare system, the paternalistic model under the old regime continues to influence the position of nursing.

In line with these assertions, interview participants conveyed that, in general, the position of nurses has not sufficiently progressed. It is argued that the lack of status manifests itself in the current nursing shortage, which is considered as one of the most pressing issues. Due to the disconnect of nurses' qualification, level of competence and pay and other working conditions, nursing is generally not regarded as an attractive occupation. Nurses are still largely regarded as “maids”. The translation for the Czech term for ‘nurse’ literally means ‘health sister’, which already indicates the implied assumption that nursing is an occupation for women.

*...it isn't a very attractive [occupation]....*(Interview 6)

*the work of nurses...here in the CR is not valued at all..*(General nurse 2, hospital South)

Regarding nurses' role at that time of the communist regime, Heitlinger (1999) describes that nurses were a ‘jill-of-all-trades’ (p. 167) and that “there was no social support for a concept of client service (...) work activities in the public sphere (including paid caring labour) were often considered less important for one's identity and prestige than private family-based activities”.

This historical picture of a nurse and a nurse's role and status, resonates with the categorisation by Dent (2003) and the emphasis on strong familial values as typical in transitional regimes.

### *Professional organisations/associations*

The historical background of the Czech Republic could be argued to have influenced the status of nurses but also the role of the trade unions and professional associations. Due to the common perception of "unions as remnants of communism" (Kaminska, 2013, p. 73), which also came through in the interviews conducted, their identity and legitimacy has been undermined. Sirovátka and Hora (2013) expand on this issue of weak pressure groups in the Czech Republic. Due to the previous collaboration with the Communist regime, trade unions still lack legitimacy and only recently and slowly are regarded as trustworthy in the public's view (Vanhuysse, 2007; Sirovátka and Hora, 2013). Indeed, trade unions and professional associations reportedly have low membership levels and, based on the interviews, it appears that the view of unions is still tainted somewhat by its historical legacy.

*Unions were before the revolution...mandatory, back then it was a repressive body which directed, instructed and threatened...(manager for non-medical healthcare, Hospital North)*

In the interviews, trade unions were described as "not overly strong" (e.g. Head Nurse; former member of the Presidium of the CAS). As there is no higher-level collective agreement in the Czech healthcare sector, collective agreements can only be concluded at the organisational/hospital level. However, even there the scope of collective bargaining is restricted by the Labour Code (ECOTEC, 2006).

*[unions'] role is very weak...unions don't have a major role in any way. (manager for non-medical healthcare, Hospital North)*

The most relevant trade unions in relation to nursing are the Union for Health Care and Social Care (*Odborový svaz zdravotnictví a sociální péče – OSZSP ČR*), and the Professional Sector Union of Health Care Staff (*Profesní a odborová unie zdravotnických pracovníků- POUZPČMS*) which is both a professional and trade union. Overall union fragmentation and competition prevails in the Czech healthcare sector, though there have been instances of cooperation (Veverkova, 2011). Although the concerns of professional associations tend to revolve around issues like "professionalism, quality of care, education" (chairman at CAS) and trade unions are primarily concerned with salaries, it was reported that both types of organisations now intend to work more closely together (Chairman at CAS).

The lack of political power of professional associations to influence nursing-related decisions is regarded as limited by interview participants. This is also evident in the tendency to reverse the



educational system, although professional associations (and trade unions), including the main nursing association - the Czech Nurse Association (CAS) (Svobodova, 2013) - oppose this as they regard this as contributing to the de-professionalisation and degradation of nursing. According to national stakeholder interviewees, such associations can be invited to talks and may be consulted on various issues, but they do not have a vote and ultimately no 'voice'.

*CAS...unites only a fraction of those sisters/nurses, and practically doesn't have any strong voice.* (former member of the Presidium of CAS; current Chairman of the specific department)

*...no one takes us seriously into account...our comments are not accepted 90% of the time.* (President of Professional and trade union for healthcare workers)

Even though professional associations and unions have little input or decision-making power in policy issues, and regulating and governing healthcare they do have other functions such as licensing and monitoring professional conduct (Kaminska, 2013). Yet all in all, the available evidence points to a lack of influence of nursing associations in the Czech case.

Furthermore, interview participants associated the limited influence of nursing at the political level with the lack of a nursing chamber. Initially, after the Velvet Revolution in 1989, professional associations such as the Czech Medical Chamber, the Czech Dental Chamber and the Czech Chamber of Pharmacist have been formed (again). However, an equivalent nursing chamber does not exist and, as according to Andersen (2006), the most powerful non-state actors are doctors' associations when it comes to Czech health policymaking. Yet, overall, the state retains its dominating position in the wake of the weakness of the social actors (Kaminska, 2013; Sirovátka and Hora, 2013). There used to be a debate about the establishment of a nursing chamber and eventually something akin to a working group was established to move the debate forward. Already at that stage however, the focus became on the establishment of a chamber for all non-medical healthcare workers rather than just for nursing (as originally intended by nursing associations). However, the momentum of this discussion has faded and was blocked at the political level. It was particularly highlighted that, yet again, doctors – who themselves have a chamber and a big lobby - are opposed to this and “wouldn't want this to happen” (Interview 4: Professional and trade union for healthcare workers) and are influencing the political decision not to enshrine this chamber into law. However, it is argued that a chamber would be necessary to improve the capacity for negotiation and influence.

*..we'd come up against the government and MP's, especially doctors who have a chamber and don't want nurses to have their own...And as we all know, among MPs and senators there are many doctors and there's a big lobby...so professional chamber of healthcare workers or nurses never occurred...the project is stopped. It's very bad.* (Professional and trade union for healthcare workers)

*...there's not much strong professional support. The Czech Association is weak, trade unions handle other things, and there is no chamber, so here I'm a little skeptical. (Head nurse; former member of the Presidium of CAS)*

Finally, it is worth noting that there is now a central register for general nurses in the Czech Republic. Re-registration is required at a 10-year interval and encompasses the obligation to collect a certain number of continuing professional development credits. Previously, a nurse would have had 6 years to collect these credits/points but the time frame has been extended in an attempt to increase the number of registered nurses, in the context of nursing shortages. According to interview participants, the current set-up is ineffective as the requirements for further development are 'very little'. Whilst the general concept is welcomed, it is regarded to be not sufficiently developed.

### *Nurses' education*

The Czech Republic has experienced many changes regarding its education system for nurses. Under the Soviet Union, nurses' training shifted from nursing schools (post-secondary education) to nursing-specific secondary schools (Matousova and Tollarova, 2014; Tóthová and Sedláková, 2008). This meant that the path to becoming a general nurse was to attend a vocational secondary school, i.e. a secondary medical school, for four years (after primary school from age 6-15). This development is argued to have had negative consequences as nursing became to be understood not as a profession in its own right but as an assistant role (Tóthová and Sedláková, 2008). Over the long-term this view has become deeply embedded in the country, and through education these notions have been reinforced through the 'hidden curriculum' (Matousova and Tollarova, 2014). Thus, the low status was a result of the way nursing had been taught, i.e. "where the nursing students were lead to obedience, discipline, observance of rules (....)" (Tóthová and Sedláková, 2008, p. 34), and the dominant position of physicians.

Since the fall of communism, one of the most pressing issues was to upgrade educational requirements for nursing although initial progress had been slow (Heitlinger, 1999). More recently, since joining the EU in 2004, the Czech Republic was required to harmonise legislation and standards. Subsequently the education system shifted and currently, to become a general nurse, a Bachelor or equivalent-level degree is necessary (Rokosova and Hava, 2005). Interviewees confirmed that the influence of the EU was the key driver for changes in this regard. The change meant that the 'old' path would no longer result in becoming a general nurse but instead a healthcare assistant. To become a general nurse, in addition to completing secondary

(medical) school, further education needs to be pursued for an additional three years at a university to obtain a bachelor (the common route) or another higher medical college [i.e. bachelor-equivalent degree]. Nurses who graduated under the old system can continue to work as a 'full' general nurse without additional qualification, although those who in managerial positions are generally expected to complete a bachelor or equivalent degree.

Therefore, there are now a range of (general) nurses practicing in hospitals with different educational backgrounds, yet all have the same competencies. As such, even though the system has moved to a higher education level, the competencies newer graduates bring are not fully utilised as the level of competencies tends to fall to the lowest common denominator.

*Nurses could assume greater competence, but don't make use of it because doctors anxiously defend theirs...[nurses'] education isn't comparable..the competence of nurses are set according to the lower educated (manager for non-medical healthcare, Hospital North)*

The role of doctors and their influence over nursing has been highlighted throughout the discussion around the state of nursing, as also in relation to the allocation of work/competencies. This is in line with Matoušová and Tollarová (2014) who consider the asymmetrical nurse-doctor relationship and argue that the legacy of socialist healthcare wherein doctors had absolute authority and nurses were merely subordinates is still present today and is "only beginning to change" (p.841).

*..it's always about if nurses even need HE for this menial work...that [they're] too expensive...They don't realise that one could save expensive doctors if they'd let the nurse do what she was educated to do...(manager for non-medical healthcare, Hospital North)*

Often the underlying assumption is that higher-level degrees of education will eventually lead to increased prestige for the profession (Bártlová and Tóthová, 2006; Davies, 2008, p.935). However, there are recent reports of intentions to abolish the current system. Under these new plans, nurses would only have to complete one year of vocational training after secondary school. The reason for these plans to, in effect, reverse earlier changes made, is because the current system is regarded by some as having contributed to the nursing shortages. It is argued that the amount of time it takes to qualify as a general nurse is too long and by shortening it, this will help to combat the lack of nurses.

Nursing associations and trade unions are strongly opposed to this planned change. The move is essentially regarded as a step backwards and not a solution to the nursing shortages. Rather, to increase the number of nurses, it is argued that pay and working conditions and the overall status of nursing needs to be improved. However, trade unions and professional associations

have little influence over the educational changes planned or related matters. The key players who seek this change are the health ministry and doctors. It is thought that apart from increasing the number of nurses, due to a quicker turnover of graduates, the latter (doctors) also aim to maintain the status quo and hinder the further professionalisation of nursing as they perceive it as a threat to their own profession. Because of the planned alignment back towards the old system, it is feared that this constitutes a setback regarding the professionalisation of nursing and indeed a 'absolute degradation of nursing' (Professional and trade union for healthcare workers). Moreover, it is feared that this will lead to a decrease in the quality of nursing care.

*...this [change]...is completely unsystematic and absolutely punitive...we need adequately paid nurses and working conditions...and certainly not to return to an educational system at a lower level..doctors still think that [they] must influence nursing education, which is complete nonsense. (Professional and trade union for healthcare workers)*

In sum, the current state of nursing in the Czech Republic was examined to determine its potential influence over PA practices. Based on national stakeholder interviews yet also considering findings from the hospital-level fieldwork and publicly available information and the wider literature, it can be concluded that Czech nursing institutions have limited influence in key nursing-related decisions. Indeed, the planned reversal of the educational system for nurses illustrates that even regarding education, nursing institutions have no impact. Nursing is considered as an unattractive occupation and still regarded as the doctor's assistant. Despite former discussions around a nursing chamber and subsequently around a chamber for all non-medical staff, this discussion has subsided. Again, the government, the health ministry but also doctors with their powerful lobby are interfering in such nursing-related issues. All this suggests that in relation to PA, nursing institutions have limited scope to influence its practice and PA is not nursing's main concern or priority matter. Indeed, nursing institutions do not appear to engage with the subject of 'appraisal'.

## 6.2 Prevalence & types of PA for nurses in the hospital sector

Based on the interviews conducted, it can be determined that Czech hospitals either have no formal, structured PA system for nurses in place at all, and at the most conduct ad-hoc/unstructured discussions with staff, or alternatively, hospitals tend to have an PA system best described as (individual) 'performance evaluation'. This implies that points are given for a certain set of criteria and that the established criteria are systematically evaluated. Indeed, appraisal forms across different hospitals in the Czech Republic were equated to a yearly school certificate where grades are provided regarding specific points. The extent to which this is combined with a complementary discussion around the evaluation results varies in practice but emerged to not be a substantial part of the PA process. It was consistently maintained by national stakeholder interviewees, including participants from a range of different hospitals, that the reason for introducing PA is related to hospital accreditation as their requirements stipulate this, as already highlighted in section 6.1.1 in relation to 'quality management'.

*If the hospital has some kind of external quality assurance, then in any case PA is conducted. If no external quality check is made...then it is not done. (Czech Association of Nurses (CAS))*

Official statistics are not available regarding the use of PA in hospitals or the exact number or percentage of accredited (or certified) hospitals. Given the consistent link established between accreditation and PA in the Czech Republic, interviewees estimated that all accredited hospitals would have a formal system of appraisal in place whilst un-accredited hospitals would tend not to. It was estimated that around one third to half of Czech hospitals are accredited and as such have implemented appraisal. Others were more optimistic in their estimation and suggested that up to 80 percent of all Czech hospitals (public and private) are nowadays accredited and therefore practice appraisal.

According to the interview participant from the main relevant Czech accreditation body, the need for PA is clearly prescribed and there are even clear guidelines in terms of what it should constitute. Yet, the statement below also indicates that the need to *fully* comply with this one single element within a set of many other standards might be debated, as each 'standard' has to be fulfilled to 50 percent.

*The most important [thing] is that it's documented that the employee has valid qualification...next is the definition of competences...PA..that's pretty strictly specified...for nurses who regularly do a certain activity, e.g. Endoscopy, it's also checked whether their competence still exists...each chapter has to be fulfilled at least to 70% ...each standard has to be fulfilled to 50% or more...[With ISO]..it's likely that this [PA] is integrated into..the group of standards for management. But it's not so concretely described at ISO..as with us. (Co-founder, Chairman and auditor at SAK)*

This means that, whilst the need to utilise PA is prescribed by the accreditation and certification bodies, the way in which appraisal is *precisely* conducted, including the specifics of the appraisal form, are up to the management of the hospital to decide. As such, there is *some* flexibility regarding the details of PA which is within the realm of the hospitals' management. For example, there would be scope to further develop PA and to include developmental-orientated elements into the PA process. However, in practice hospitals were found to primarily seek to comply with the basic requirements in order to fulfil this 'standard', resulting in PA with an emphasis on evaluation. The management may theoretically consult e.g. WC representatives where present, however both the decision to implement PA and the structure and content of PA is ultimately a management decision and does not require authorisation.

*The criteria are set by the hospitals themselves. It's the decision of the management. (CAS)*  
*[accreditation] forces us to conduct staff appraisals every two years and the form and way in which we do it is up to us...It's forcing us to ensure that each employee has firmly established competencies. (Head Nurse; chairman at CAS)*

Despite the clear tendency of the use of PA in Czech hospitals in the form of performance evaluation, there is scope for some variation within this type of PA. A major state-owned hospital in Prague, identified as one of the hospitals which was quick to embrace external quality assurance soon after the revolution, was found to have a quite elaborate and sophisticated system of performance evaluation in place. This means that the appraisal form was very detailed and followed the guidelines from SAK CR most closely. In this case, appraisal included, alongside the evaluation of criteria such as e.g. *"attitude to work, compliance with working hours, adherence to 'standards', communication in a team, communication with patients/family"* (Head Nurse), the regular check of competencies of nurses. If a certain work activity (e.g. doing transfusions) has not been carried out for a certain period, this competency would be taken away from the nurse, so that he/she would not be allowed to perform this particular task unless e.g. appropriate refresher training was undertaken.

Other examples of performance evaluation were provided in interview 3 (Deputy Director of nursing care and quality at a hospital in Prague), interview 8 (Midwife, East Czech Republic) and interview 9 (Czech nurse with 5-year experience of working in the NHS, UK). The case of Hospital South will discuss their use of performance evaluation in more detail. All of these systems of PA have the marking of a particular set of criteria in common, which is the focus of these evaluations. However, the giving and taking of competencies as part of PA was not reported in any other of those instances and therefore does not appear to be a common feature. Instead,

interview participant 4 (President of Professional and trade union for healthcare workers) summarised the experiences of hospitals using PA more generally like this:

*What I know of some large hospitals, where we have a large representation...PA doesn't take place the way as it was intended...nurses get some form which they fill out in 15 minutes,...the ward manager or head nurse writes some comments – but that it would be a downright session, conversation or discussion with the employee, in that way it doesn't take place at all..it doesn't work... they take it like a necessary evil, just got to do it, you fill in a paper and with that it's finished for them. (Professional & trade union for healthcare workers)*

Thus, since hospital management usually adopts PA to comply and tick the box in relation to the requirements as set out by accreditation standards, the tendency is that PA itself becomes a tick-box exercise and a ritual, as is further illustrated in the hospital cases. Whilst the account of the trade unionist above of PA in the context of public hospitals is critical, others have argued that this pressure for hospitals to acquire accreditation and the related need to introduce PA is generally a positive development because otherwise it would not be done at all.

*That's positive pressure [that one has to conduct PA for accreditation] because if you would leave it to the hospital, then nothing happens..that's the only such force which is able to mobilise a hospital nowadays...(Head Nurse at big hospital in Prague; chairman at CAS)*

Nonetheless, another potential aspect of performance evaluation is that the amount of a yearly extra payment – which may or may not be provided, depending on the hospital's financial/economic situation– can depend in part on the result of the nurses' evaluation, as was reported in Interview 3 (President of CAS and Deputy Director of nursing care and quality of a big hospital in Prague), although on the whole this was not reported to be a prevalent element.

In conclusion, a strong link can be discerned between external quality assurance (i.e. accreditation) and the implementation of PA in Czech hospitals. Hence, predominantly two scenarios have emerged based on the interviews: a) either hospitals do not have formal/structured systems of PA or b) PA occurs in the form of 'performance evaluations' to comply with the accreditation guidelines and standards. As hospitals increasingly seek accreditation, the practice of PA increases in hospitals across the Czech Republic. Although there is some scope for variation within the broader type of 'performance evaluation', the overall tendency is clear. PA tends to constitute the grading of a pre-determined criteria and is therefore focused on the assessment and judgement of competencies.

The next section discusses the state of PA for hospital nurses at two Czech hospitals. It further discusses key national institutional drivers for implementing PA (i.e. hospital accreditation), which in turn is influenced by broader pressures in the Czech hospital sector. Further, it addresses the questions regarding the 'why', the 'how' and the consequences of PA for nurses.

### 6.3 Hospital case No. 3: Appraisal at hospital “South”

#### 6.3.1 Background: tradition and type of appraisal

Hospital “South” did not have any system of PA in place before its introduction in the form of ‘performance evaluation’ about 10 years ago (approx. 2006) which now affects all levels of nursing staff. The nature of PA has not changed since. As further discussed below, the introduction of PA is directly related to the hospital-wide certification and accreditation processes at this hospital. Although annual extra payments are paid when the current hospital’s financial situation permits, and the exact amount can be varied amongst staff broadly related to PA, there is no elaborate system of linking PA results to bonus payments, and it is up to the individual head nurse to decide the precise method for distribution.

#### 6.3.2 Drivers: Institutional factors influencing the approach to PA at hospital South

##### *External Quality assurance: Hospital accreditation*

The key driver for having introduced and maintaining the use of PA at Hospital South relates to the need to comply with requirements by the certification and accreditation bodies. The underlying reasons for Czech hospitals to pursue hospital certification and accreditation explored in part 6.1.1, was reiterated at this hospital in terms of, firstly, increased prestige and secondly, the expectation that hospitals will be remunerated more favourably by health insurance companies in the future, while those who are not are already being disadvantaged. Moreover, there were general suggestions that by being accredited, hospitals seek to protect themselves against potential hospital or ward closures. This became apparent in this hospital case as well, particularly as hospitals are increasingly becoming accredited in the wider context of hospital competition. Within the same region/district of hospital South, there are three further hospitals within a short distance, who can be identified to compete with each other (see quotes below). In the recent past, certain wards had already been closed at Hospital South, which are now only provided by the others in the region.

*We belong to the district...There’re three [hospitals], and we had a time when we were afraid of each other, whether [it’ll be] them or us, that they close us down...three hospitals so near to each other, that also seemed a lot to them...currently it’s ok because we now have only basic wards...We had a maternity ward, not anymore...(ward manager 4)*

*Hospitals are competing, of course, because there are a lot of us here...(WC, chair)*

The nursing director of the hospital distinguished between two key types of certification and accreditation the hospital currently has. Firstly, since 2006 the hospital is certified according to ISO [‘International Organization for Standardization’]. All wards/units of the hospital are



certified according to ČSN EN ISO 9001:2009 and the Department of Laboratory Medicine according to ISO 15189: 2007 (accredited by the Czech Institute for accreditation). Secondly, the hospital is accredited by Euro Cert CZ (‘akreditaci zdravotních služeb’) and obtained the certificate entitled ‘certificate of the verification of quality and safety of healthcare services’ (Certifikát o ověření kvality a bezpečí poskytovaných zdravotních služeb) in 2013. Eurocert is one of nine organisations endorsed by the health ministry to conduct external audits within the scope of accreditation and certification (MZCR, 2017). Based on the hospitals’ yearly activity reports and the interviews conducted with the managing director and nursing director (who is also the hospital’s representative for quality management), it can be discerned that preparations to comply firstly with ISO requirements and secondly with accreditation-related guidelines commenced prior to the actual seeking of these certificates thorough external audits.

The 2010 activity report suggests that ahead of the accreditation, which was eventually completed in 2013, the hospital began to ensure it fulfils all requirements ahead of time. For this preparatory phase, the hospital used the guidelines by SAK CR, the main accreditation body within healthcare, although it was subsequently accredited by EuroCert. Already before obtaining the ISO certificate(s), the hospital began to implement necessary changes in advance to ensure its compliance with the associated norms. These preparations clearly included the introduction of regular, structured, and formal PA, which is one of the many external requirements. Appraisal forms had been developed for this purpose, mainly by the managing and nursing director. Yet, both also reported that managing staff had the opportunity to comment on the forms. During external audits, auditors may take samples of completed performance evaluation forms which are stored in the respective personnel files of staff to check for evidence and fulfil this criterion concerning PA.

*We started in 2006, when we introduced...ISO-standards..we put such documents, guidelines, in order and we ‘tidied up the house’...then the staff evaluations started to take place...That’s a part [of it]...we have to do it...(Nursing director)*

The hospital’s yearly activity report further highlights the importance of its accreditation efforts, and indicates that it is a part of its overall long-term strategies and thus plans to continue to engage with these processes: “The quality policy issued by decision of the (Managing) Director declares a long-term vision, and directs the hospital to create a stable hospital that provides quality healthcare in a safe environment (...) In October 2013, the hospital received accreditation in the field of health services and related service activities - medical, rehabilitation and nursing care. The certificate is valid until 2016 (...)” [Activity report, 2013]. Since hospitals must re-certify on a regular basis to ‘defend’ their certificates and accreditation, PA continues to be practiced.

### *Role of works council and local trade union*

As discussed in section 6.1.2, neither trade unions nor WCs emerged to play a role regarding PA in the Czech case. The introduction of PA is essentially a management decision as confirmed in many of the interviews conducted. Fieldwork-level interviews confirmed the highly restricted role of the WC. The deputy chairwoman of the WC at Hospital South reported that the WC is a voluntary organisation and constitutes voluntary, unpaid work. Given the voluntary nature of the WC, its members solely meet once a month to see if there are any urgent issues. The role of the WC revolves primarily around the implementation and organisation of lower-order working conditions such as the organisation of social gatherings, certain employee benefits such as: vouchers/discounts for public swimming pools; staff discounts for (hospital) lunches; as well as the organisation of the staff's annual leave (given that in the Czech Republic there are around two months summer holidays for children all at the same time, which makes the organisation of annual leave more complicated).

*Our organisation specialises in annual leave of employees, employee benefits, that working hours are adhered to, health and safety of employees, including safety training...we organise the Christmas gathering, meet with former employees, pensioners' meetings, excursions, we take care of sports activity...(Deputy chairwoman, WC)*

Thus, as can be seen from the quote, overall, the WC's scope of influence is limited to implementation and ensuring compliance with those aspects covered in the collective bargaining agreement. As discussed in section 6.1.2, it is the role of the trade union to negotiate a collective agreement with the individual hospital. Yet, again, the role of the trade union in the public sector is limited because pay is essentially determined centrally. The fact that the role of the trade union and collective bargaining is overall limited is best illustrated by the fact that, as according to the nursing director of Hospital South, the decision to link the additional annual payments to appraisal was taken by the hospital's management and did not require or constitute the involvement of the WC or trade union. This is also due to the fact that such bonuses are funded by the hospital and may thus vary year on year depending on the financial performance of the hospital. Equally the introduction of appraisal itself does not require authorisation by the WC or any other committee or union.

Moreover, it was established in section 6.1.2 that while occasionally financial rewards may be paid in Czech hospitals, taking into consideration the results of performance evaluations, there is a lack of external and therefore also internal regulation for the payment of such rewards. Similarly, Hospital South lacks an elaborate system for the distribution of bonuses. As emerged in several interviews, each ward is provided with their bonus budget for the year whereby these

costs are also moderated. When financial rewards are distributed it does not following a clear pre-determined system e.g. with specified percentage distribution guidelines. Instead, the precise method of distribution occurs at ward-level and is often associated with an a-rule-of thumb approach and even favouritism. This highlights the local nature of these initiatives and ad-hoc nature of the process. This is in line with findings by Hedija (2016) and the fact that in the Czech Health and Social Services “it is not common for collective agreements to establish precise rules on the application of such discretionary pay components” (EPSU, 2017) due to the lack of a regulation by law. Furthermore, the amount of any potential bonus is usually so modest that it is often not acknowledged as a bonus, as emerged in Hospital South and further highlighted in the following sections regarding the ‘why, ‘how’ and consequences of PA.

In sum, due to wider hospital pressures, such as hospital competition, there is this drive for hospital accreditation which represents an important part of the employer’s strategy. This in turn has led to the introduction of PA in the form of performance evaluations.

### 6.3.3 Why? Main purposes of appraisal

#### *Adherence to external requirements*

Most nurses clearly referred to the need to conduct regular PAs and attributed this to external requirements which have to be fulfilled by the hospital. Many were also specifically aware that these requirements are associated with certification processes which makes PA necessary. This issue naturally emerged during interviews without the need to probe and at different levels, i.e. ward managers/supervisors and general nursing staff alike were all able to make the link. In fact, to satisfy the requirements as set out by relevant accreditation/certification bodies was identified as the sole and overarching reason for PA. Likewise, it was argued that the PA forms have been created specifically for that purpose, namely of being able to show evidence to external auditors that regular appraisal of staff indeed takes place, and – by extension - that the recommended ‘standards’ are followed. Thus, overall appraisal was argued to have been designed to initially get and subsequently ‘defend’ the hospital’s certificates. The certificates themselves serve the primary purpose of certifying an adequate level of ‘quality’. As such, it was furthermore suggested that appraisal, like certification/accreditation itself, aims to improve the overall quality of work.

*...it started when we wanted to get/defend ISO, certificate of quality...That’s definitely why [we have] staff evaluations...To defend ISO and improving the quality overall throughout the hospital...we just have to do it (Ward manager 1)*

*We have a range of certificates and accreditation, so we must of course comply with such things...[PA] has to be done. (Head nurse 1)*

Participants who did not specifically raise the issue of certification/accreditation or did not consciously make this link between these processes and appraisal, most still assumed that PA is a necessity and a requirement which has been prescribed at “the top” and/or externally. It was repeatedly stated that ‘it simply has to be done’ and that PA is not a practice the supervisor chooses to use. Instead, there was a general agreement that managing staff had been instructed to comply with regulations and therefore must evaluate its staff in this manner. Hence, there is an understanding amongst nursing staff that the formal appraisal of their performance is not due to the will of their immediate superiors. In any case, the general speculated purpose of PA, alongside the fulfilment of (external) requirements, was described as making performance more visible to upper management levels.

*Staff assessment is required according to regulations – it must be. It’s not [like] that’s just our will...it’s part of administration. That’s the only reason. It doesn’t have any meaning...it’s something which has to be [done] (HCA 3)*

*...I think that it’s {PA} some kind of provision from above, probably something for the [health] ministry....(General nurse 2)*

*The ward manager also doesn’t just do it because she wants to...she’s been instructed to do so...probably instructed by the ministry [of health] or something like that (General nurse 1)*

*maybe so that the nurse in the management position knows how her staff works...(General nurse 3)*

### *Appreciation and Motivation*

During the interview with both the managing and nursing director, i.e. those who decided to introduce PA, the link between certification and appraisal clearly emerged. However, despite the acknowledgement that the hospital ‘had to do it’ for the sole reason of accreditation, it also appeared that the hospital’s management rationalised the decision to introduce appraisal and extended their explanation for this practice, highlighting the benefits of staff appraisal itself. These benefits were described in relatively general terms, namely to ‘see how the employee works’ (see quote below). Further, it was suggested that appraisal can be a tool to motivate staff by showing appreciation. Reference was also made to the financial reward aspect, which management intended to be motivational.

*It’s a part [of certification], we have to do it. But it is mainly also for us, so that we can see actually on the one hand how the employee works, how his direct superior evaluates/assesses him/her, and evaluates him/herself... [managing director]*

*So that the person on the one hand knows that we appreciate his/her work and so that he/she is able to give the best he/she can...So that they can freely develop...or the appraisal, if it’s excellent, it can lead to/boost rewards...financial motivation (Nursing director)*

#### 6.3.4 How? Process of appraisal

Interviewees described the PA process in similar ways. The nursing director conducts the PA of head nurses/divisional managers, who in turn evaluate their respective ward managers. Ward managers are responsible for evaluating their staff, i.e. general nurses but also healthcare and nursing assistants. The completed evaluation forms are then handed over to the head nurse/divisional manager and stored on the ward in the respective personnel files of each staff member. There are slightly different criteria for e.g. general nurses and healthcare assistants (HCA), however they are all similar in nature. Below the appraisal form for general nurses is illustrated (appraisal form for HCAs in appendix 2). The criteria used, as shown in the appraisal forms and recalled by interview participants, indicates that attempts are made to focus on more 'measurable', 'visible' and verifiable criteria. All interview participants described the assessment criteria in similar terms. Most participants equated the appraisal form and indeed PA as a whole to a school certificate as it implies the use of grades from 1 (A) to 5 (E).

The only and main difference which emerged in relation to the process was that some reported that short discussions take place between the supervisor and staff regarding the completed evaluation form (e.g. HCA 1) whilst in other cases it was reported that no such discussions are conducted (e.g. General nurse 2). In the latter case, the by the supervisor completed evaluation form would simply be handed to the nurse in question, who would then have to indicate whether he/she agrees with the evaluation by signing the form accordingly. However, even in those instances where it was reported that a discussion occurred, it was suggested that this did not take very long. As emerged in the interview with the nursing director, it was certainly intended by the management of the hospital that PA would encompass a discussion during which the employee would evaluate him/herself first and only then the evaluation by the supervisor would take place. Yet, in practice this step is often skipped or a secondary feature.

*The process should include a discussion [with staff] however if they indeed have a discussion with everybody...that's another question, because there's so much work that there's not much time... (Head nurse 1)*

Regarding the various elements which constitute the 'how' of PA, as according to the typology established in Chapter 2, it can be suggested that Hospital South reflects discipline-orientated elements. The focus of the PA process overall is on the evaluation and formal assessment of past performance against pre-determined criteria via a rating form. It is short-term in nature and includes only a minimal concern for 'development' in the form of one vague criterion of "Professional growth (...) active participation, collaboration". The lesser concern for further development is also reflected in the survey data, which indicates that only for 56 percent of

respondents who have had a PA in past year (n=138; 20 missing cases) any type of training or development needs were identified within the scope of PA.

**Figure 6.1: Appraisal form at Hospital South (general nurse)**

<b>Applies to: Hospital "South"</b>		Issue Date:
<b>Appraisal of employee performance</b>		1. October 2009

<b>Name of employee:</b>	<b>Grading scale</b>
<b>Department:</b>	0 – not applicable
<b>Position:</b> General nurse	1 (A) – exceeds requirements
<b>Date of appraisal:</b>	2 (B) – meets requirements
<b>Evaluation period:</b>	3 (C) – slightly below requirements
	4 (D) – below requirements
<b>Appraiser:</b>	5 (E) – not suitable for the given position

Evaluation criteria	Result	Notes
Conduct towards patients		
Conduct towards superiors and co-workers		
Teamwork skills		
Personal pace		
Ability to provide support in challenging or exceptional situations		
Organisational skills		
Initiative, effort to improve care and treatment ...		
Participation in introducing new (active nursing care) methods and processes		
Professional growth – seminars – active participation, collaboration - personal development		
Compliance with methodological instructions regarding nursing care, as well as guidelines relating to disinfection and sterilisation		
General preparation (nails and hands without embellishments), use of OOPP (personal protective work equipment)		
Attendance and utilisation of working time		

**Statement of the appraisee:**

I agree

I do not agree

I agree with restrictions

**Signature of the appraisal:**

**Signature of the appraiser:**

Moreover, the frequent lack of an accompanying discussion signifies that there is little scope for participation. Performance comparisons are conducted between individuals in theory because PA is envisaged to be connected to individual-based bonuses based on performance levels. However, the lack of institutionalisation of this system means that it is predominantly not used in this manner, as will be explored further in the consequences section.

### 6.3.5 Consequences

There was a general understanding that PA must be conducted due to *external* requirements. Consequently, no internal ownership of the PA system could be detected, particularly amongst managerial nurses (divisional or ward nurses). Because of nurses' experience of PA as having no significant consequences due to the absence of a significant bonus, many expressed feelings of indifference towards this practice. However, there were also reports of increased monitoring and control and a more general sense of a lack of appreciation. As nursing staff understands that PA is not conducted due to the will of their immediate superiors, frustrations are predominantly directed at the PA system itself. Indeed, many nurses can be identified to have become disgruntled with the system and do not perceive it to be a useful instrument, in a context of general dissatisfaction especially regarding levels of pay.

#### *Appraisal overall accepted*

Although for the most part, no positive consequences of PA could be identified by interview participants, there was a general acceptance of this instrument. It is understood by nursing staff that PA is a practice which is demanded and has to be conducted as part of general requirements and largely due to external reasons. Over time therefore, staff has become accustomed to the PA procedure (e.g. General nurse 8; head nurse 3). PA is now acknowledged as a necessary element of the employment relationship albeit one that is solely a "formality". Mainly the fact that PA can be attributed to external requirements warrants its acceptance.

*I take it as a part of employment...it has to be done (General nurse 1)*

#### *Limited effect & little consideration for further development*

As indicated, nurses have now understood for themselves that PA has a limited effect on them, whether positive or negative. If performance levels are below the required standard, this is usually handled outside of the PA process anyway. If performance is solely not good, there are from the perspective of nurses limited negative repercussions. This is partly associated with the small size of the bonus (see section below). The only reported potential positive outcome of PA is that one is happy to receive a good evaluation, but this effect is rather short-lived.

*When it's good it's good, when it's bad then one is sorry..Others don't take it too seriously [and say] 'I don't care, I [still] have the job' (General nurse 3).*

*PA doesn't have an effect on work..I mean, I am pleased if [manager] sees some positiv things about me but that it would have any effect– no...it's a little strange that she evaluates me.. (General nurse 8)*

After continued questioning, it was indicated that some nurses take the feedback they get onboard however ultimately, nurses of all levels were skeptical of the overall effectiveness of PA. Overwhelmingly, it was argued, PA adds little in terms of improving performance, communication, let alone motivation, or anything else, as staff communicates with each other regularly anyway e.g. during meetings within the team (in-between/transfer). Furthermore, no strong link could be identified between appraisal and training or further development. The only connection is that “personal development” is one of the points assessed on the appraisal form. However, it was explained that this is a minor point within the overall evaluation. Again, this is reflected in the survey results: 44 percent (n=138) suggested that *no* training, learning or development had been identified as part of their appraisal, which suggests that personal development is less of a focus of appraisal.

In general, the issue of ‘further training’ is regarded as a separate one and rather relates to the re-registration of nurses. This re-registration takes place every 10 years and has been described by many nurses as “completely ridiculous” since the requirements are considered as low. It was further suggested that for the most part, nurses take care of further training themselves, although the hospital does offer some training and seminars at the hospital (e.g. ward manager 3) and supports nurses who decide to pursue e.g. a bachelor degree in the form of extra time-off. This is reflected in the survey results: in those cases where training and/or developmental activities had been identified, all of the participants (100 percent; n=80; 17 cases missing) indicated that the manager supported them to receive this training.

Survey responses were somewhat more positive in terms of the effect PA can have insofar that of those who have indicated that they have had an appraisal in the past year, about two thirds answered ‘yes’ (66.9 percent) however about one third ‘no’ to the question ‘did it help you to improve how you do your job?’ (n=145, 12 missing cases). During interviews however, it was emphasised that PA has limited effects on nurses’ work and therefore nurses expressed that they are dissatisfied with the system. The appraisal itself was said to not last very long, and indeed is often conducted within 5 minutes or less. It is largely regarded as an unnecessary feature, especially given the general stressful working environment and other priorities. The way in which appraisal is structured (e.g. the feature of grading performance) is also seen as non-conducive. Arguably, as ward managers are aware that PA is solely conducted to satisfy external requirements, they are not convinced of the usefulness of PA themselves and tend to only comply with the minimum requirements, i.e. the completion of the appraisal form, which has a knock-on effect on the way in which nurses perceive PA, namely as ‘useless’.



*I don't see a lot of sense in this evaluation...(Ward manager 1)*

*.. it doesn't have any effect...it means nothing to me..this is a piece of paper..(HCA 1)*

*..to get a piece of paper once a year, that's useless. (General nurse 3)*

*I get nothing from it, not I, not the employer, it doesn't achieve anything...it has absolutely no consequences...(HCA 2)*

*for me it is useless, it doesn't make a difference. (General nurse 6)*

### *Lack of staff discussion*

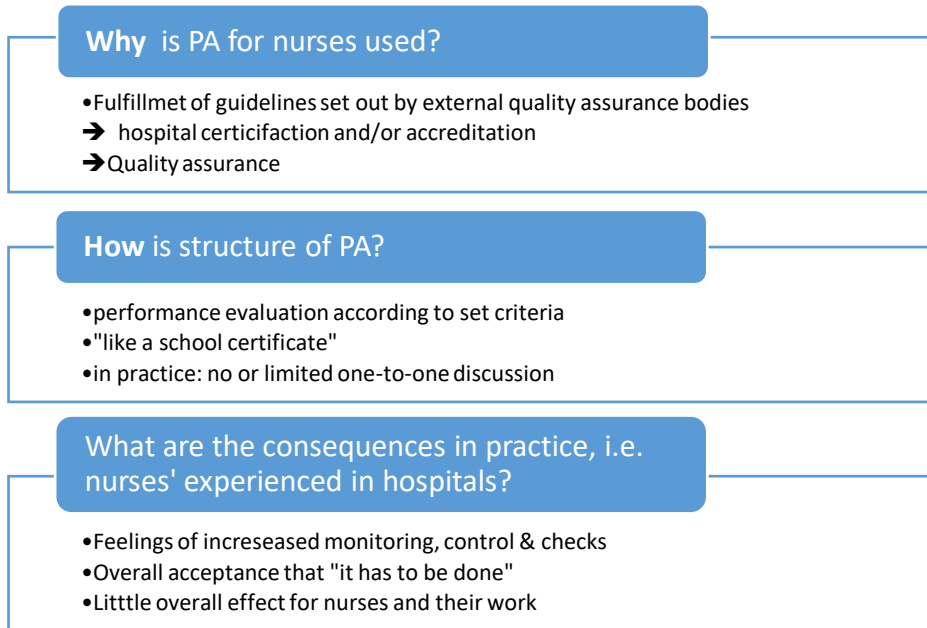
The reported lack of a discussion around the evaluation results contributes towards the perceived 'uselessness' of PA. As mentioned above, some interview participants reported that a discussion takes place during the handover of the appraisal form, whilst the other half of interviewees said that no such discussions occur and simply a signature from them is sought. This could be attributed to the fact that divisional and ward managers are not convinced of the usefulness of the practice themselves but rather tend to perceive it as a practice which needs to occur in order to adhere to external guidelines. As such the focus is on complying with the (minimum) requirements. Consequently, at times, little explanation is given to staff regarding the results of the evaluation. Interview participants tend to share the same opinion regarding the (potential) usefulness of staff discussions. Whilst most would welcome a discussion with the manager about the outcome of appraisal, there were also suggestions that it would not add anything to the process. It was even argued that a focus on staff discussion would also not be effective due to the perception that "to express one's opinion is not liked" at the hospital (e.g. General nurse 5).

*I don't need a conversation [discussion], nothing, I distance myself from/ avoid it, it doesn't get me anything..for me all this doesn't really matter (HCA,1)*

### *Scoring issues*

The fact that PA is viewed as having little impact arguably relates to scoring issues raised. At least some managerial nursing staff have been reportedly told not to give perfect scores, i.e. an A, during evaluation. Indeed, there was a general awareness that it is not possible to get the highest mark, regardless of performance levels. At the same time, it has been reported that nurses are rarely rated worse than C, since this would imply that the nurse's work performance is inadequate, which should not be the case in the first place. As a result, many nurses tend to receive similar scores in their PA. Consequently, the extent to which the scores are taken seriously is limited. Regarding the appraisal form itself, most interview participants were content with the criteria used. Nevertheless, it was stated that the points which are assessed are quite general, that the assessment is inherently subjective, and has therefore overall little effect.

**Figure 6.2: PA at Hospital South according to dimensions of PA**



#### *Lack of significant performance-related bonuses*

Reports were inconsistent in relation to the payment of an annual financial reward and whether this is linked to individual PA results. According to the hospital's management, yearly bonuses are paid to staff and the amount is differentiated depending on the outcome of PA. The divisional or ward manager would be responsible for the distribution of this extra payment, with the budget being set by the upper management. According to the hospital's management, this 'system' was decided by the hospital management itself and did not require the involvement of either the WC or trade union. As noted previously, in the health and social services in the Czech Republic bonuses and other performance-related pay components lack regulation and are often not included in collective bargaining agreements and therefore an internal system with specific rules is also often lacking (EPSU, 2017; Hedija, 2016; Saltman et al., 2011). As bonus systems are not effectively institutionalised this signifies that performance-related bonuses become an informal practice, which explains the different experiences of nurses in relation to this issue, as different narratives emerged.

Indeed, some suggested that occasionally this premium is paid and differentiated on the basis of PA outcomes however it was emphasised that the overall amount is small (in the region of just approximately 65 GBP gross per year). As such, the difference in payment and overall amount is regarded as insignificant. So, in effect it is not recognised or considered as a reward or noteworthy extra payment since its value is considered too low to make an impact. In addition, due to the tendency of ward managers to evaluate their nursing staff at similar levels

(which relates to the scoring issues highlighted above), some ward managers reported that they opt to not differentiate bonus payments, particularly given the generally low pay.

*In the past I maybe tried to differentiate...But it's oftentimes sad when you have to reduce [the bonus]....And the girls here are all capable...So now, in recent times I gave them all the same...(ward manager 1)*

However, some nursing staff were sceptical of the actual link between performance evaluations and the additional payment. The view was expressed by a number of nurses that in fact the difference in bonus payments does not relate to performance levels achieved but rather the bonus is distributed randomly and on the basis of favouritism. Thus, no elaborate or pre-determined system for bonus allocation was established, and the bonus amount is not strictly related to PA outcomes but might rather solely be guided by them. This, in turn further contributes to the discontentment towards the PA system.

*...here we only get a bonus around Christmas and that's also 'based on the face' [i.e. favouritism]...one nurse might get nothing...another one 2,000 KC and so on but it has nothing to do with staff evaluations...It probably depends on how well one is liked...here nothing is connected to anything. Here PA is absolutely useless (HCA 2)*

Some further highlighted that, given the the bonus is directly funded by the hospital, the extra payment is based on the hospital's overall financial performance/situation and, in many cases, it was suggested that bonus payments have not been paid recently although they were in the past. Notwithstanding these mixed messages, in principle, nursing staff overwhelmingly suggested that it would be positive if PA would be linked to noteworthy (differentiated) performance bonus payments. Only then, it is suggested, PA would have a strong effect and indeed a positive one in terms of motivation. In this context, it was argued that salaries are generally too low and therefore higher bonus payments would be appreciated even if these would depend on performance.

Survey results reflect the striking dissatisfaction regarding the level of pay (n=197). Of those who responded, 42.1 percent indicated that they are dissatisfied with their level of pay, and 15.7 percent are strongly dissatisfied. 10.7 percent were neither satisfied nor dissatisfied. Solely 5.1 percent indicated that they were very satisfied. As the general level of pay is considered low, this might explain why nurses indeed showed a great interest in connecting PA more strongly with higher levels of performance-related reward if this would signify more pay. However, as yet, the impact of PA on bonuses is essentially considered as non-existent, especially given its inconsistent and non-transparent set-up.

### *Increased monitoring & control*

Nurses also conveyed the feeling of being monitored and controlled more broadly as a consequence of external audits and inspections taking place within the process of regular re-certification. Although PA is conceived as a ritual, nurses argued that the individual PA of staff further contributes towards feelings of 'control', continuous monitoring and increased performance pressures. This was expressed by general nurses, other nursing assistant personnel and also ward managers who are both required to control and check on their staff more as well as being subject to more assessments themselves. According to ward managers the control of staff performance within the scope of appraisal mostly relates to the performance of basic work-related tasks (e.g. ward manager 1).

*More controlling...in terms of everything...all the time one has to check on them [nursing staff]...complete professional deformation...it's stressful...there's a lot of [pressure] and it's difficult. (ward manager 1 )*

*PA...It's such a control...(General nurse 1).*

*[PA] is just so our management can control us and get an idea about us..they're monitoring us continuously...(General nurse 8)*

Moreover, most consider appraisal at this hospital to be somewhat like a test akin to a school certificate whereby nurses' performance is graded. This was often conveyed to be perceived as condescending since many nurses, firstly, have worked in their position for several decades and therefore feel it is inappropriate to be treated like pupils. Secondly, some of the general nurses are educated up to bachelor or even master-degree level and similarly perceive appraisal as rather unappreciative. Again, the issue of monitoring was raised in this context which some nurses feel uneasy about, whilst others feel unaffected by it for the most part. In addition, there appears to be a lack of information amongst (general) nurses in terms of what exactly happens with the evaluation forms and who has access to them, which adds to the feeling of uneasiness about the process (General nurse 3; general nurse 1).

*one is afraid who's monitoring whom where...probably they continuously keep watching us. (HCA 2)*

*One isn't being appreciate here...[PA] is ridiculous...(General Nurse 5)*

Survey results further reflect the notion that PA is not considered as an appreciative practice. To the question 'Did [PA] leave you feeling that your work is valued by your organisation?', 53.6 percent (of those who indicated that they have had an appraisal in the last 12 months [n=140; 17 missing cases]) indicated that it did *not* leave them feeling valued.

This finding is in line with the level of satisfaction amongst participants regarding the statement 'The recognition I get for good work', to which (n=196; 4 missing) 28.1 percent of respondents indicated that they are dissatisfied, and 6.6 percent very dissatisfied, whilst 21.4 percent were 'neither'. Still, 37.2 percent stated that they were satisfied in relation to this, however just 6.6 very. A similar distribution of responses was found to the statement 'The extent to which my organisation values my work'. Of 194 respondents, 22.2 percent indicated that they are dissatisfied, and 6.7 percent very dissatisfied, whilst 24.2 percent were 'neither', although 38.7 percent stated that they were satisfied in relation to this, and 8.2 percent very.

#### 6.3.6 Summary and conclusion

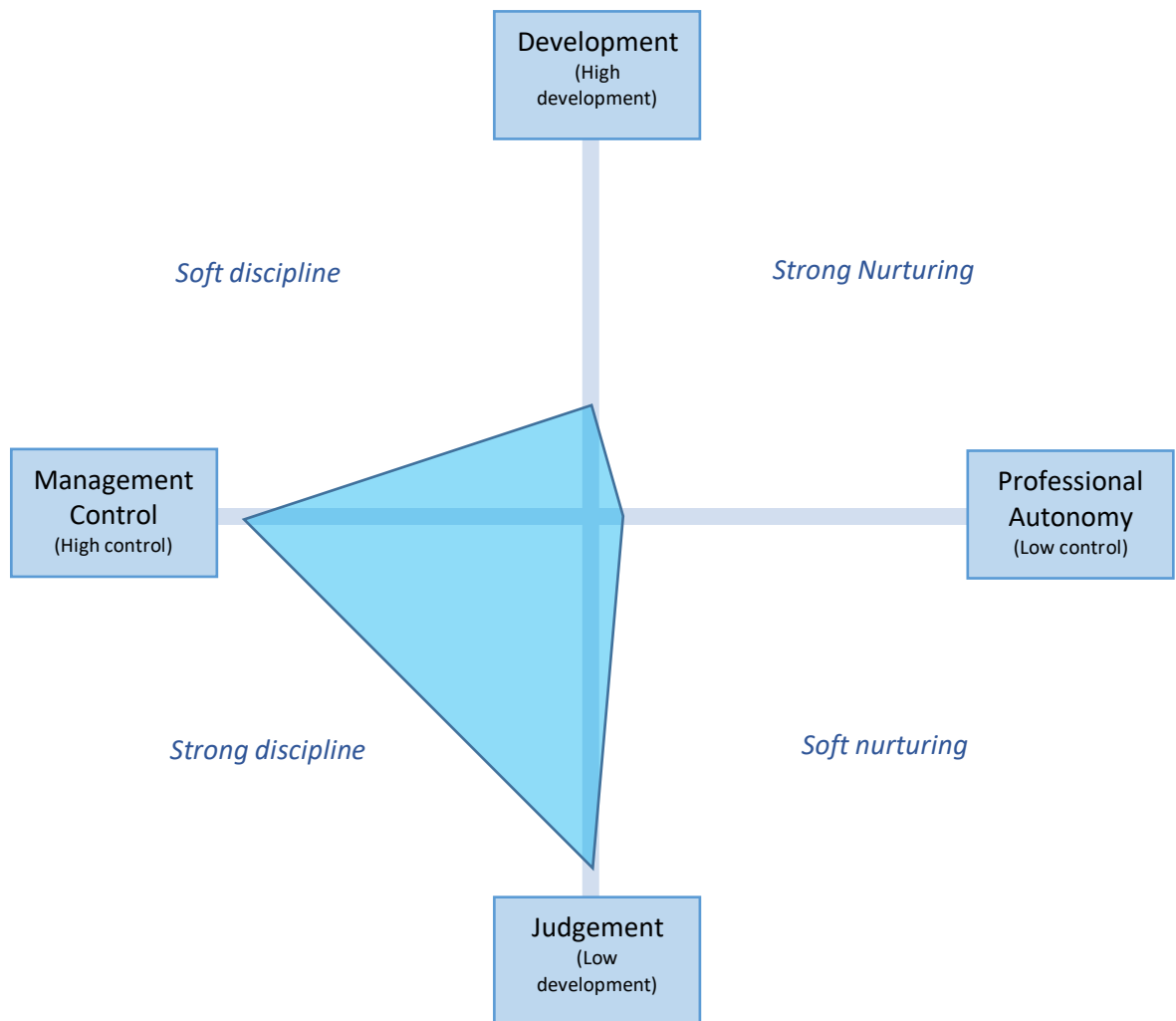
In terms of scoring on the framework for comparison, again, the first stage involved that each case has been analysed by comparing the four dimensions and the sub-dimensions (provided in table 2.4) within the particular case. The second stage of analysis was to compare across the four cases on each dimension to guarantee consistency across cases. Considering the framework for comparison and the findings of the fieldwork, it can be suggested that PA at this hospital is predominantly geared towards judgement and control. The former manifests itself clearly in the appraisal form, which entails the assessment and evaluation of various aspects of nurses' 'performance' by the superior using grades. Given the frequent lack of a staff discussion alongside the formal evaluation, this element involving judgement is the predominant aspect of appraisal. Furthermore, when participants discussed the purpose of PA during interviews, the predominant conclusion was that appraisal represents yet another control mechanism, in this case related to external [certification] requirements and processes which ultimately seek to ascertain adequate levels of quality within the hospital.

More specifically, nurses associated PA with increased monitoring and judgement-making regarding performance levels, and indeed in some cases intensified performance pressures. Whilst on the whole appraisal was reported to have limited effect for nurses in relation to tangible outcomes, i.e. bonuses, the majority expressed resentment and conveyed feeling discontent with this practice in the context of general dissatisfaction. However, active resistance could not be discerned, as some of the literature would predict (e.g. Simmons and Eades, 2004), and in general, PA has become an accepted albeit unpopular feature of employment.

This general acceptance derives primarily from the knowledge or belief amongst nursing staff that PA is an external requirement (brought about by e.g. legislation, health ministry, certification/accreditation) which has to be fulfilled. Thus, acceptance is based on the perceived necessity but also a certain level of understanding for the wider purpose of PA [i.e. assuring

quality, hospital accreditation requirements]. This echoes the literature which underscores the importance of attributions of the “why” in relation to HR practices (Nishii, Lepak and Schneider, 2006). Due to the external attributions made and PA being associated with the need to comply with external demands, nurses likewise comply and tolerate the practice of PA. While no active resistance could be detected, passive resistance could be discerned. This implies the use of more ‘subtle forms of resistance’ in the form of treating PA as a formality and tick-box exercise and solely complying to a minimum extent with this ‘necessary evil’.

**Figure 6.3: Framework for comparison: Hospital South**



Source: Author’s own compilation

Thus, as can be seen throughout the case, external factors stemming from the national institutional context directly contributed to the approach to PA taken at this hospital and affected all dimensions of PA. This hospital was compelled to use PA and in the form it did, namely performance evaluations, due to external hospital accreditation requirements

associated with the national system for external quality assurance. The drive for external accreditation amongst hospitals is informed by the wider national context and wider pressures hospitals in the Czech Republic are confronted with. Widespread hospital competition, further reform debates including around privatisation, fears of hospital or ward closures and hospital mergers alongside fiscal pressures, especially for municipal and regional hospitals such as Hospital South, combined all contribute towards hospitals seeking accreditation in an effort to 'protect' themselves. Due to PA being a practice which is introduced solely for external reasons, in response to external requirements, little internal ownership of the PA process can be discerned. The limited influence of nursing and the lack of employee voice mechanisms means that PA is introduced 'unfiltered'. This in turn affects the way in which PA is practiced and interpreted, namely primarily a 'tick box' exercise.

An interesting aspect which emerged during the course of interviews was that the employer provides annual financial rewards to its staff which it envisages to be paid on the basis of performance evaluation outcomes. The exact implementation and distribution of these payments is within the scope of the divisional and/or ward managers of a particular ward. While some have opted to differentiate pay slightly according to performance levels, others distribute the financial amount equally. Yet others reported to receive no bonus whatsoever although simultaneously stating that they do get 'something' at Christmas. This unsystematic implementation of PRBs at Hospital South can be argued to be a manifestation of the fact that such matters are not regulated either by law or via collective bargaining agreements and thus their implementation lacks specific rules (EPSU, 2017; Hedija, 2016). Hence, in the Czech Republic the centralised legally regulated collective bargaining system is silent about bonuses enabling more informal and less transparent bonus systems. Nevertheless, in any case, the financial amount is within such a low region (around 30 GBP net) that it has limited implications. However, nurses repeatedly emphasised that they would be keen on a system that combines differentiated bonuses linked to appraisal if the amount would be sufficiently high and systematically linked to performance— only under these circumstances they believe appraisal can have a valuable effect. This echoes findings from research conducted in the English NHS which suggest that hospital staff tend to approve of such a practice in principle, but whether nurses would be in favour of it in practice is another matter (Corby et al., 2003).

## 6.4 Hospital case No.4: Appraisal at hospital “North”

### 6.4.1 Background: tradition and type of appraisal

This hospital case further confirmed the strong interrelationship between certification/accreditation and PA in Czech hospitals. Thus far, this hospital has certain units certified under ISO namely for ‘the provision of technical, operational, economic and business services’ of the hospital, specifically in the following areas: Pharmacy, Medical Supplies Shop; Department of Sterilization; Receiving Room. In addition, it has special accreditation for its laboratories. These specific external accreditations are mandated by law, and each hospital needs to accredit these areas/units. However, unlike Hospital South, the hospital is not accredited hospital-wide and none of the healthcare wards currently are, as this remains a voluntary process. Currently, the hospital is solely required to have internal quality management processes in place. However, the hospital’s long-term strategy involves the external accreditation of the hospital as a whole (planned in 4-5 years) which will then imply the introduction of a hospital-wide PA system. More specifically, it will introduce PA in the form of performance evaluation. Similar to Hospital South, Hospital North distributes bonuses to nurses in the region of 30 GBP on an ad-hoc basis and in a non-transparent manner.

### 6.4.2 Drivers: Institutional factors influencing planned adoption of PA at hospital North

#### *External Quality assurance: Hospital accreditation*

Although Hospital North thus far has not introduced a PA system for nurses, as established throughout the Czech case, the key impetus for *planning* to introduce an annual, structured, mandatory PA system is related to the hospital’s plan to gain external hospital-wide accreditation, which in turn requires this practice. Regarding the reason why the hospital wants to undergo this, as yet, voluntary process in the first place was discussed during interviews. A level of uncertainty could be discerned which motivates the hospital to consider and undergo external accreditation in the foreseeable future. This uncertainty relates to the potential but not guaranteed ‘promise’ of the health insurance companies that, eventually, accredited hospitals will be in a more advantageous position and receive higher payments. At the same time, it is speculated that further down the line, hospitals in the Czech Republic might be actually required by law to have external accreditation, as is the case for certain units already, such as laboratories. Furthermore, accreditation is perceived to enable smoother implementation of certain practices. As new practices, such as PA, would be attributed to the demands of external



organisations, it is argued, staff are more likely to accept changes (such as the introduction of PA).

*I think this will occur gradually [accreditation will become necessary by law]...the reason why we want it [anyway, voluntary] is that the Czechs need a whip, otherwise they won't do anything...if...it's an accreditation requirement, then it's easier to implement (manager for non-medical healthcare, Hospital North)*

The preparation process for gaining accreditation has gradually begun by starting to implement certain 'standards'. It is acknowledged that this preparatory phase and associated implementation of changes is necessary because as of now the hospital would not be able to fulfill a range of requirements and therefore would not be able to acquire accreditation at this stage. Furthermore, there are various factors which have slowed down the actual process of gaining accreditation. This specific hospital has experienced changes in its organisational and management structure as it is no longer managed by one main managing director but has a three-person management board which is said to be an untypical set-up and has resulted in delays in decision-making more generally.

Furthermore, there seems to be some uncertainty surrounding the decision regarding which accreditation body to choose, as various such companies have arisen in recent times in the Czech Republic. Consequently, the hospital is somewhat hesitant in its decision, particularly because accreditation implies an initial investment for hospitals. Given that different accreditation companies provide their services at different costs, the hospital seeks to ensure that the cost/benefit ratio is adequate. It was noted that large state hospitals in the Czech Republic are in a better financial situation to those smaller hospitals in surrounding cities. Therefore, although the hospital firmly plans to accredit the hospital in the coming years, given the uncertainties and investment it implies, the hospital is more careful in its approach. Furthermore, arguably given news reports of financial difficulties of the hospital (Idnes, 2016), *immediate* concerns and priorities do not revolve around accreditation and hence, it has not yet implemented a hospital-wide PA system.

#### *Role of works council*

As highlighted throughout the Czech case, at Hospital North it was reconfirmed that neither the role of trade unions nor WCs extend to decisions regarding either hospital accreditation or the adoption of appraisal. Whether accreditation, and with it, appraisal is introduced at the hospital is solely a management decision. In this particular case, the decision is made by the managing director together with the Members of the Management Board.

*unions exist. But...their role is very weak. Unions don't have a major role in any way...we're obliged to discuss with unions e.g. if we wanted to lay off a high number of employees...Or changes to working times, working hours, overtime hours...But essentially, whether the hospital decides for accreditation –unions have no say in that (manager for non-medical healthcare, Hospital North)*

#### 6.4.3 Why? Main purposes of appraisal

Given that legislation requires hospitals to accredit laboratories externally (only), this hospital has accreditation but solely for this unit. Further, it has certification solely for those units which are legally required to (e.g. Central Sterilization). Given the close interrelationship between appraisal and accreditation or certification which manifested itself throughout the Czech case, these specific units have an annual, formal, structured PA system in place. The appraisal form for laboratory technicians was provided by the hospital. The remaining un-accredited and uncertified hospital wards are not covered by this PA system and as such there is no annual, structured PA mandated for general nursing staff. However, given the perceived need to acquire hospital accreditation, as an increasing number of hospitals are becoming accredited, Hospital North likewise plans to seek accreditation, and by extension, plans to introduce PA, also for nurses. As such, the main reason for introducing formal PA at this hospital, now as in the case of laboratories and e.g. central sterilization, and in the future also for nursing staff, relates to the compliance with external accreditation requirements. It was stated that currently, head or ward managers are free to decide to conduct staff discussions with their staff in their respective division, however whether they chose to conduct such discussions and the way in which they conduct them is essentially up to them.

In interviews conducted with nursing staff it was confirmed that everyday communication takes place, for example during hand-overs, and some suggestions were made that e.g. ward managers praise their staff on occasion or provide some ad-hoc feedback in individual discussions, particularly if problems or other specific issues arise. However, overall, a lack of feedback and PA in any form was reported.

*PA? That doesn't work here. There's no feedback here. Here no one says thank you for your work. [PA] (...) that wouldn't work anyway (ward manager, Hospital North)*

At the units which are either certified or accredited and thus have a regular and formal PA in place, the connection between external certification/accreditation and PA was clearly made and the overarching reason for PA associated with these external requirements, such as the quote below of the Head nurse at the department for central sterilisation indicates. Therefore, PA was associated with the need to 'control' and the 'checking' of employees' performance.

*Our unit is certified according to ISO 9001, so of course, already this certification implies a number of obligations, which poses me to inspect/control my subordinates. Within my unit,..daily...I'm there, so I can see, I look, control...This meticulous writing of everything [came with external control] certainly. (Head nurse (central sterilization), Hospital North)*

Although it was suggested that upper management would prefer not to introduce mandatory PA unless accreditation required it, the reason for why accreditation bodies demand formal PA was speculated on. One aspect was thought to be the assurance of quality, and 'quality staff' on the one hand but also the control of staff in the sense that repeatedly underperforming staff might be eliminated, i.e. dismissed due to underperformance. However, this is regarded as inappropriate in a context of shortages of healthcare workers, particularly nursing staff.

*I think...the goal of [accreditation] is probably that we have to take care that only quality staff works in the hospital. So when we appraise them, then those who have...repeatedly negative evaluations, then they won't be able to work [at the hospital anymore]. But it's quite difficult in the current conditions...There are...major [staff] shortages (manager for non-medical healthcare, Hospital North)*

#### 6.4.4 How? Process of appraisal

It was suggested during interviews that the hospital itself has the scope to develop the specific appraisal forms used for PA themselves. Already in the case of laboratories, as well as other certified units, the hospital designed its own appraisal forms, albeit in accordance with the general guidelines/requirements by the relevant accreditation body. However, once the appraisal form is established and in use, the specific appraisal form must be used.

In the case of laboratories, the appraisal form contains 10 points or criteria which are assessed and graded on a scale from 1-10. In addition, a range of competencies are assessed. Scope is provided on the appraisal form to make additional comments regarding targets that had been potentially set, or other general comments. Both the appraiser and the person being appraised have to sign the appraisal form. The appraisee also has to indicate whether he/she agrees with the evaluation. It can be expected that the appraisal form for nurses will have a similar format, albeit with a different set of criteria. The appraisal form for lab technicians is illustrated below. Considering the elements of the 'how' of PA established in Chapter 2, PA in this case can thus be suggested to be rather discipline-orientated in the sense that PA is concerned with the evaluation of past performance. Moreover, it is rather short-term orientated, with only little concern for further development apart from being one of many aspects assessed during PA. Scope for participation is also limited and reduced to the appraised person having the formal option to disagree with the appraisal form.

**Figure 6.4: Appraisal form used for laboratory staff at Hospital North**

Employee's personal development plan and evaluation				
Title, surname and given name of employee:				
Personal number:				
Position:				
Area / workplace:				
Date of appraisal:				
Title, surname and given name of appraiser:				
<b>1. General appraisal</b>				
		<b>Max. points</b>	<b>Value achieved</b>	
1	Professional level	10		
2	Ability to enhance and apply knowledge and skills	10		
3	Ability to produce original and realistic ideas	8		
4	Quality of achievement of set objectives	10		
5	Reliability of performance (safety, observance of guidelines and other rules)	10		
6	Collaboration within the team (motivation, persuasiveness, authority, ability to deal with stress, handling of exceptional situations, collegiality)	8		
7	Economic efficiency	10		
8	Decision-making and responsibility (delegating, ability to take risks, advance solutions)	6		
9	Motivation (readiness to work consistently, purposefulness, curiosity, enthusiasm, initiative, flexibility)	8		
10	Education, seminars	5		
	<b>Total obtainable and achieved</b>	<b>85</b>		
<b>Overall appraisal</b>		%		
<b>2. Appraisal of professional competencies</b>				
Appraisal	1	2	3	4
Performed	routinely	1x every three months	1x every six months	Never *
*competence not assigned				
<b>Competencies assigned based on position</b>				
				<b>appraisal</b>
<b>1</b>	Independent performance of laboratory analyses			<b>1 2 3 4</b>
<b>2</b>	Development, verification, preparation and application of laboratory methods			<b>1 2 3 4</b>
<b>3</b>	Organisational and technical safeguarding of diagnostical operation			<b>1 2 3 4</b>
<b>4</b>	Creation and modification of documents relating to duly laboratory practices			<b>1 2 3 4</b>
<b>5</b>	Consultative and professional activity within the scope of hospital			<b>1 2 3 4</b>

Currently, in the non-accredited and un-certified units, which are those relevant to nursing, no formal PA system is in place. Head nurses or ward managers may conduct discussions with their staff on a voluntary basis. There are no guidelines for the way in which discussions should be held and as such it is entirely within their scope.

*In the units which aren't accredited, it's voluntary...it's up to them [head nurses] if they want to do e.g. staff discussions and how...(manager for non-medial healthcare)*

Based on the interviews it can be suggested that such discussions solely occur on a sporadic basis, and rather rarely, in an informal manner. This is also reflected in the survey data. Of those who participated (n=172; 3 missing cases) just 39 percent indicated that they have had an appraisal/ annual review/development review/appraisal interview in the last 12 months.

In those cases where it was indicated that PA occurred in some form, it might be that in these cases some sort of discussion regarding performance has taken place within the scope of the adaptation process where an 'appraisal' is required for those who newly start working as e.g. a nurse. Apart from appraisal which is mandated by the adaptation process, based on the interviews it can be suggested that any appraisal is likely to have been conducted ad-hoc and in an informal manner.

**Figure 6.5: Appraisal form used for laboratory staff at Hospital North (continued)**

<b>6</b>	Evaluation of cases of technical errors	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>7</b>	Development of preventive measures for cases of technical errors	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>8</b>	Responsibility for the professional level of the entrusted operations	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>9</b>	Responsibility for the management at Department of Clinical Biochemistry and Hematology	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>10</b>	Processing of conceptions and optimisation of systems	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>11</b>	Participates in the continuous training and professional development of the employees at Department of Clinical Biochemistry and Hematology	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

**3. Appraisal of the fulfilment of assigned tasks**

	Assigned task	Evaluation of results
<b>1</b>		
<b>2</b>		
<b>3</b>		
<b>4</b>		
<b>5</b>		

**4. Definition of future tasks**

	Definition of tasks	Expected date for task to be completed
<b>1</b>		
<b>2</b>		
<b>3</b>		
<b>4</b>		
<b>5</b>		

**5. Proposed measures**

**Figure 6.6: Appraisal form used for laboratory staff at Hospital North (continued)**

<b>6. Remarks by the appraiser</b>		
<b>7. Remarks by the appraised employee concerning the appraisal undertaken</b>		
<div style="border-bottom: 1px solid black; margin-bottom: 5px;">I agree – I disagree</div>		
<b>Appraisee:</b>	<b>Signature:</b>	<b>Date:</b>
 <b>Appraiser:</b>	 <b>Signature:</b>	 <b>Date:</b>

A related but separate issue is that of bonuses. While small bonuses are paid, in the region of approximately 30 GBP, it is dependent on the hospital's performance rather than staff's performance and there is no transparent internal distribution system in place. It was conveyed that in the instance that a bonus is provided in any given year, it is the divisional manager who is responsible for the distribution of bonuses on their wards.

*[hospital management] try to, if the insurance gives what it should, for example last year we had a financial bonus before Christmas, but little..(ward manager, Hospital North)*

*bonuses aren't custom..it depends on how...the hospital as a whole performs, then some [financial] bonuses are distributed how the superior sees fit...if there's a bonus, I don't think everyone in the team [i.e. ward] gets the same, but we don't get to know. One doesn't talk about that...we don't tell each other. (General nurse, Hospital North)*

#### 6.4.5 (Expected) Consequences

Since only the more technical units of the hospital have formal PA in place, general nursing staff as well as managerial nursing staff (e.g. ward managers) interviewed reflected on how they would perceive PA in hypothetical terms. What emerged was firstly that in the current wider national context of nursing and staff shortages, increased patient load and more demands in terms of administrative work, it is predicted that PA would be difficult to implement due to a lack of time. In general, it is difficult for most nursing staff to imagine PA in practice since they are not used to it and have not experienced it before.

*Because now there's a crisis at hospitals in the Czech Republic: staffing shortages, a surplus of patients...If there would be more staff then PA would be ok, but in this situation, one doesn't even think about it that one can even go and appraise something. One is glad when one manages to do the work and goes home [General nurse, Hospital North]*

Secondly, whilst most are in favour of feedback-type discussions, which they predict they may find appreciative, in contrast, more formal, criteria-based PA is seen in critical terms. Doubt was expressed in relation to the possibility to appraise performance objectively and it was questioned who would be capable of assessing or appraising nurses' performance. Related to this, a frequent issue raised was that much of the work for nurses on the wards constitutes working as part of a team. Accordingly, participants were skeptical of the usefulness of PA and its ability to take the team-element into account in a way that it does not damage the necessary trust within the team. Especially the use of grades or points to rate performance is not regarded as suitable and it is predicted that such a type of PA would be demotivational.

*Who could appraise us [our performance] as a whole? No one is with us the whole time. Which person? it doesn't work. We're always only a part of a team, we work as [a team of] two or three, so it's always teamwork and who is supposed to appraise what. [Ward manager (nurse), Hospital North]*

*I can't imagine it [PA]...with numbers like in school, that can be very disappointing. Numbers don't capture the effort put in...it isn't objective. If [PA] then orally, in words. But I can't imagine it in reality how to do it so that it doesn't cause any damage...[General nurse, Hospital North]*

Again, there was a general agreement amongst participants that PA in the form of informal feedback, either individually or as a team, would be something they would be more positive about. It is acknowledged that currently feedback and especially regular praise is lacking and that positive feedback would be perceived as appreciative. At the moment, if any problems arise, these are communicated and dealt with immediately anyway already, thus PA is argued to not be required to handle performance issues which have to be addressed in a timely manner. The notion conveyed in the interviews that appreciative feedback is lacking is reflected in the

survey results which indicates that nursing staff does not feel valued to a large extent. Even in those cases where it was indicated that an appraisal (probably in an informal, ad-hoc manner) took place, the majority of survey participants indicated that they did not feel valued as a result (52 percent; n=60). Similarly, regarding the statement 'The extent to which my organisation values my work', survey results indicate that most participants are either dissatisfied (28 percent), very dissatisfied (4 percent) or 'neither satisfied nor dissatisfied' (31 percent), while just 35 percent are satisfied and 2 percent very satisfied.

Overall however, from the point of view of nursing staff, structured and formal PA is something which is predicted would not be effective, as indicated by the quote below, neither in the sense that it would affect the way in which nurses work nor their motivational levels or feelings of appreciation. Furthermore, it was noted that given the organisational tenure of nurses which tends to be long (which in turn was connected to staffing shortages and a lack of young people pursuing the nursing profession) and therefore "long and well-established teams" who work together on certain wards, this makes regular and formal PA unnecessary. Nevertheless, it was stated that nursing staff would not resist the implementation of PA if it would come to it.

*[formal, documented] PA wouldn't be motivational for me...I can't imagine it, it probably wouldn't have a big effect..neither good nor bad* [General nurse, Hospital North]

The predicted (positive) consequences of the future introduction of appraisal for nursing staff are viewed even by upper management staff as limited. It was suggested that if there was no need to implement PA in order to get accreditation, then the hospital would opt to keep the practice of appraisal voluntary rather than obligatory and informal. It is expected that nursing staff will have the tendency to initially feel "uncomfortable" as they are not used to being "watched" which would be the case since PA would imply a certain level of monitoring and control. It is also thought that in time, the PA process will solely become a formality with little effect or meaning to nurses themselves, apart from that the nurse might be pleased about positive feedback. Overall however, PA is not expected to have any motivating effects. Instead, the expectation is that everybody involved is likely to exert minimum levels of effort and solely fulfill the minimum requirements regarding the PA process. As indicated above, it is unlikely that more negative performance evaluations would have negative repercussions given the broader context of a shortage of healthcare staff and the need to retain these employees.

*...If it was a positive assessment [PA], then it would maybe please [the nurse]. But they aren't accustomed to being watched. So for the most part they'd probably not be pleased, especially when the appraisal was negative..I don't think it would be generally positively viewed. Of course, if it was necessary because of some specific reason, e.g. that it will be required for the*



*accreditation process, then the employees will surrender and will try to go through the PA [process] with as little effort as possible..they'd fulfil it to a minimum extent. But it won't be motivating for them..Of that I'm really afraid.... that when it'll be an obligation, it would be a formal affair. That the head nurses just copy it and it will have no meaning. (manager for non-medical healthcare, Hospital North)*

The prediction of the consequences of PA as described above was reflected in the interviews conducted with nursing staff. Nursing staff also highlighted that although they would likely have negative feelings towards formal PA, they would accept the practice if it is introduced due to external accreditation requirements and comply as necessary. Furthermore, it was also stated that in general it is difficult to implement change in Czech hospitals, and if anything like PA would be introduced simply for the sake of it, it would not gain much acceptance. As such, the reason of external requirements would make implementation of new organisational practices easier.

*...if we go to the wards and say this and that has to be like this...because it's a requirement of accreditation, then it is easier to implement than if we'd say: do it like this [just] because we want it like that. (manager for non-medical healthcare, Hospital North)*

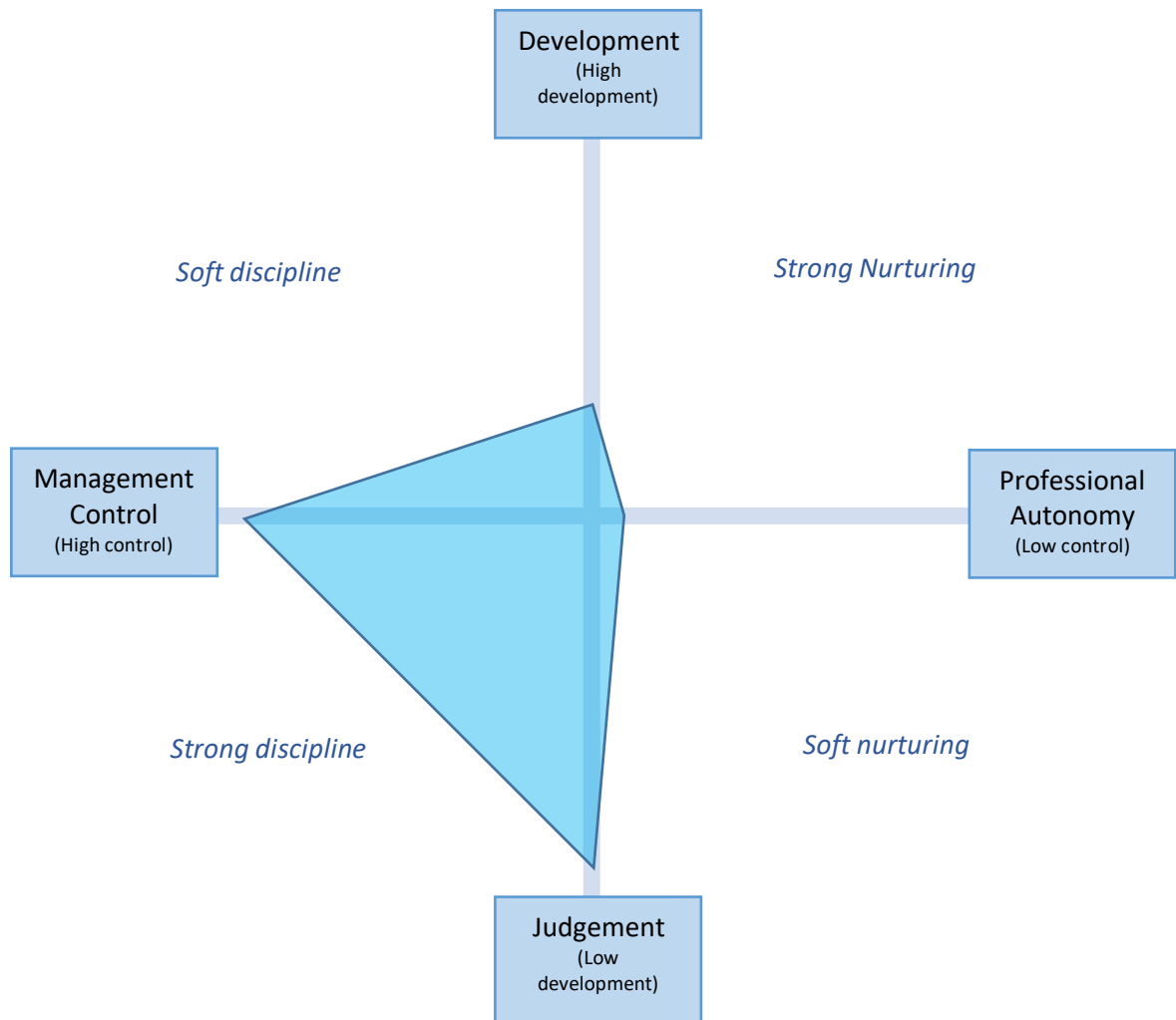
In relation to bonuses, it was already mentioned that these may be paid, provided that the financial situation of the hospital permits as it is funded at the hospital-level but, given that no formal PA system exists specifically for general nurses, bonuses are not formally linked to individual performance evaluations. Yet, the amount of the bonus may vary somewhat from nurse to nurse, however, the amount of any bonus is considered small (in the region of 30 GBP). Dissatisfaction in relation to the amount of the bonus, the lack of transparency of the bonus system and general dissatisfaction with the level of pay are reflected in the survey results. In fact, satisfaction levels regarding pay were lowest at this hospital, followed by Hospital South. Furthermore, nursing staff stated during interviews that especially in the context of low pay and low, ad-hoc bonuses, they would appreciate rewards in the form of vouchers for cosmetics or a massage.

#### 6.4.6 Summary and conclusion

Fieldwork at this hospital confirmed the strong link between certification and/or accreditation and PA. At this hospital, only those units are certified or accredited which have to be according to current law. These units are usually of a more technical kind, for which ISO norms were originally established, such as Central Sterilization or Laboratories. The other wards, i.e. 'healthcare wards' do not have any certification/accreditation. Mandatory, structured, annual PA is only conducted at the certified or accredited units. Un-accredited wards, at the most, solely conduct less formal, ad-hoc discussion with nursing staff. This was reported by the higher management staff (Interview 11 and 21) and confirmed by the range of interviews conducted with head nurses of various divisions as well as general nurses.

However, the hospital plans to gain hospital-wide accreditation in coming years. This will also entail the introduction of PA for the hospital workforce, including all nursing staff. While it was not possible to categorise this hospital's approach to PA using the framework for comparison due to a lack of a PA system for nursing staff, on the basis of the appraisal form used in the only accredited unit (i.e. laboratory) it could be assumed that the 'type of appraisal' will eventually be similar for nurses namely in the form of 'performance evaluation'. It emerged from the interviews that it is likely that nurses will accept the need to conduct regular, formal performance evaluations as it will be attributed to external requirements. However, it is also feared that nurses will not be enthusiastic about the practice, will only comply with minimum requirements set out, and that appraisal overall will become solely a formality with little tangible effects for nurses or their work. Overall, external audits are already associated with increased control mechanisms, and as such, appraisal is likely to be viewed as yet another one of these methods of controls and checks. These projections are congruent with the findings of Hospital South, explored in the previous section and illustrated again in figure 6.7.

**Figure 6.7: Framework for comparison: Hospital North (projected)**



Source: Author's own compilation

In terms of how the national institutional context affects PA, it can be concluded that the widespread national pressures to seek accreditation also manifests itself in this hospital case. National systems of accreditation in turn directly influences the use of PA. Again, given the limited influence of either trade unions or WCs in the country, and the lack of influence of nursing-related institutions, the hospital's approach to accreditation or PA is not mediated or 'filtered'. Furthermore, in relation to the lack of institutionalisation of bonus systems in the Czech public sector, this has also led to a non-transparent manner in which bonuses are distributed at Hospital North.

## 6.5 Conclusion

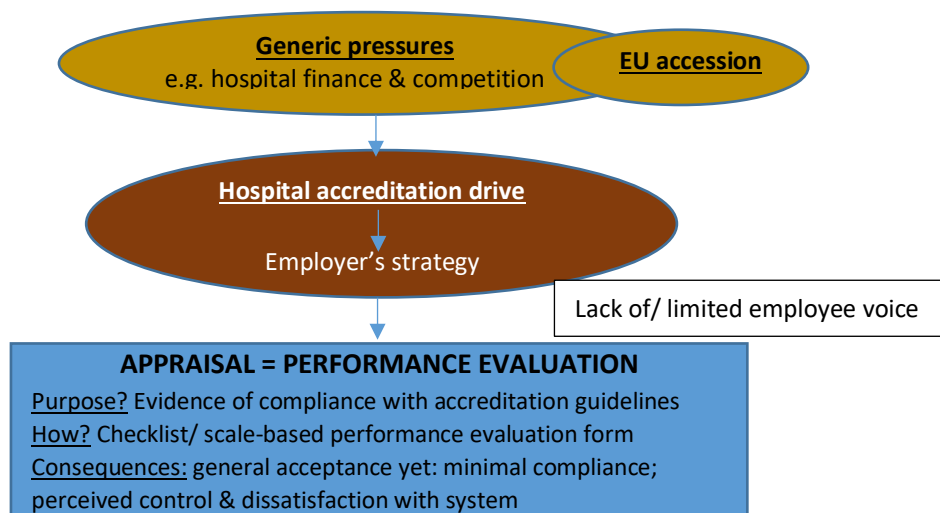
To identify if and which broader contextual factors contribute to specific approaches to PA for nurses in Czech public hospitals, this chapter began by exploring the wider national context (section 6.1), including the general hospital environment and pressures, the specificities of the employment relations system, and the status of nursing. Czech hospital pressures revolve around increased demand due to demographic developments, hospital financing issues and related to this hospital competition. This wider context puts pressure on hospitals to gain external hospital accreditation as hospitals seek to protect themselves from potential closures through these accreditations. Moreover, expectations that health insurance companies will provide higher payments to accredited hospitals leads hospitals to increasingly engage with these processes. Importantly, in the Czech case, accreditation was found to be the decisive factor for the introduction of PA at local level. Taking into account the current situation in terms of education and regulation as well as the role of professional associations and trade unions, the state of nursing was considered in more detail. Interview findings suggest that the capacity of nursing institutions to influence nursing-related decisions, including the use of PA, is limited. Regarding the employment relations system, in line with the VoC literature and the characterisation of an (emergent) LME, it was confirmed that alongside the weak position of trade unions, the WC, where present at all, has a highly limited role and is thus not capable of compensating for the lack of voice in nursing. Instead, the Czech case stood out in its emphasis placed on external quality assurance and its link to PA.

Based on the interviews conducted, section 6.2 identified the prevalent form of PA across the Czech public hospital sector, namely performance evaluation. This is connected to the main reason for the introduction of PA, as reiterated throughout the Czech case, namely external hospital accreditation. Thus, PA is designed to comply with the requirements of accreditation, which pre-necessitates staff appraisals. Hospitals typically orientate themselves on the Czech accreditation guidelines by SAK (CR). There may be some variations regarding the degree to which hospitals fulfil this requirement on PA and thus some of the specificities of 'performance evaluations'. Although performance evaluations always imply the evaluation of performance against a set of criteria using scores, in selected cases, the taking-away or maintaining of certain nursing competencies may be an element. If hospitals do not adopt PA in the form of performance evaluation, they tend not to have adopted PA at all which signifies that these hospitals do not have hospital-wide accreditation.

Section 6.3 and 6.4 presented the Czech hospital cases respectively. The two Czech hospitals primarily differ in terms of the respective stage they are at in their adoption of PA. At 'Hospital South', PA in the form of performance evaluation was introduced several years ago and has become an accepted feature of employment yet unpopular management tool. At 'Hospital North', PA has not yet been introduced hospital-wide, although there are concrete plans to do so in the near future. The main reason for having implemented PA at Hospital South and the intention to do so at Hospital North are identical. At both hospitals, the key theme which emerged in relation to PA was that of external certification and accreditation which represents an important part of the employer's strategy in both cases. The drive for accreditation in turn is informed by the wider context. The figure below summarises the key drivers which have led to the drive for accreditation and, with it, PA at Hospital South but equally other Czech hospitals, namely wider hospital pressures as well as the influence of the EU.

As figure 6.7 shows, this has led to the introduction of PA in the form of performance evaluations. Due to the limited influence of nursing as well as employee representative bodies, and the external push for PA, there is little internal ownership of the system. Hence, PA introduced as a response to external requirements has implications for the way in which PA is set up, how PA is conducted and how staff perceives and reacts to PA. The external, mandatory nature of PA leads to PA being treated as a tick-box exercise, with PA being perceived as a tool which seeks to increase management control and discipline. Due to the external attributions made by nursing staff, PA is accepted by the workforce yet a detested practice to which nurses only minimally comply. Although hospital North is yet to implement PA, it is predicted that, although accepted, PA will solely be treated as a ritual. Overall, the Czech case further demonstrates the value of taking the broader national context into account when examining approaches to PA.

**Figure 6.8: Hospital South**



## Chapter 7: Discussion & comparison of the German and Czech case

### 7. Introduction

This chapter is concerned with the cross-case analysis, i.e. the comparison of the findings of the German versus the Czech case presented in the two preceding chapters and addresses the specific propositions formulated in chapter 3 against the backdrop of the convergence-divergence paradigms. Thereby, it addresses the aim of this thesis, namely to evaluate the degree of similarity and difference of PA practices across countries and to determine how national institutions shape PA approaches for hospital nurses or, conversely, whether similarities in terms of general hospital pressures override these national differences to produce similar types of PA.

It begins by examining the shared cross-national pressures in the German and Czech hospital environment and considers if these are associated with an increased emphasis on performance and use of PA (proposition 1). Subsequently, the role of nursing and its relative level of professionalisation is assessed in both countries to be able to conclude if a high level of professionalisation amongst nurses leads to similar PA approaches in different countries (proposition 2), or if lower levels of professionalisation in either or both countries contributes to PA variation. Then, it explores if national institutions lead to distinct PA approaches (proposition 3). It identifies those national institutions which have shaped PA in each country and the ripple-down effects it has on PA at hospital level. To do this, it summarises the key findings of the workplace-level fieldwork based on the thorough analysis of the data collected, in consideration of the literature reviewed, and uses the framework for comparison, established in Chapter 2, which proved useful in characterising PA approaches. Survey data is also expanded on to illustrate key findings of variation and consequences of distinct models of PA. Finally, the extent to which national models of PA allow for some discretion, i.e. within-country variation, is considered.

## 7.1 Do shared, cross national pressures on healthcare systems lead to an increased emphasis on performance and in turn on performance appraisal?

### (Proposition 1)

As explored in Chapter 3, the convergence and universalist perspective suggests that “uniform pressures will lead to uniform (...) organizational practices” (Gooderham et al., 1999, p 507). More specifically, under this perspective it is assumed that organisations function according to the ‘logic of effectiveness’ and it is argued that as organisations face increasingly common global challenges (due to e.g. globalisation, technological innovation and general competitive pressures) this will contribute toward convergence of organisational practices, including HRM, especially when considering the same sector and region (e.g. Europe). Another central argument revolves around the erosion of national institutions, particularly industrial relations institutions which is argued to promote convergence. This notion is furthermore reflected in some of the public management literature, which suggests that, at the very least some cross-national convergence can be detected insofar that “different countries implement similar reforms from the NPM toolbox” (Pollitt et al., 2007, p.6). The NPM toolbox in turn includes, amongst other things, an increased emphasis on performance and a focus on performance management, with PA being an element of PM. In applying this perspective to the study at hand, chapter 3 further identified a range of shared pressures impacting hospitals across Europe. These pressures have been largely confirmed to be highly relevant to both the German and Czech case.

Both the German and Czech case confirmed that dual pressures for efficiency and quality exist in the hospital sector, alongside a challenging financial context. In both cases, there were reports of hospital competition and wider trends of hospital privatisation, which creates considerable organisational pressures for public hospitals. Healthcare systems in both countries are to a great degree affected by the changing demographics, in terms of an ageing workforce as well as older patients with increasingly complex health problems. The number of patients has also increased as has the flow of patients. This is furthermore connected with the reimbursement system of hospitals. In both countries, a DRG system-variant has been implemented which puts pressure on hospitals to treat more cases of patients in shorter periods of time. The ageing population is furthermore a factor which is brought into association with the severe nursing shortage in both countries. At the same time, the topic of quality management and assurance has increased in importance in both countries. Combined, these pressures lead to a heightened attention and pursuit for organisational performance and, importantly, an increase in PA for hospital nurses in both countries.

In the German case, official statistics confirm the increase in the use of PA within nursing, and whilst for the Czech Republic comparable data is lacking, interview participants have been consistent in their assertion of an increased prevalence of PA in hospitals including for nurses due to these pressures. In the Czech Republic, hospital competition, fears of privatisation and hospital or ward closures as well as planned changes to the reimbursement mechanism leads hospitals to increasingly seek external accreditation. As external accreditation requires PA, PA is increasingly implemented across the hospital sector. Thus, by extension, wider hospital pressures lead to an increase in PA. Likewise, in Germany, interview participants argued that wider hospital pressures are resulting in an increased focus on performance and increased up-take of PA. Additionally, in Germany, the nursing shortage, the lowering of entry requirements for nursing students and the lack of a nursing chamber regulating the further professional development of nurses is argued to make the use of PA more important to ensure adequate skills and performance levels at the wards. Furthermore, in Germany, it could be suggested that in *selected* cases, as evident in the *exceptional* case of hospital NRW, wider hospital pressures (e.g. hospital competition and fears of privatisation) also have the potential to influence WCs to become more flexible in their stance toward various types of PA. Thus, in relation to proposition 1 “Shared, cross national pressures on healthcare systems lead to an increased emphasis on performance and in turn on performance appraisal” it can be concluded that this proposition holds.

Taking the convergence argument further, it may be suggested that not only has the emphasis on PA increased cross-nationally, but PA practices themselves may be similar in nature across hospitals in different countries. Chapter 3 distinguished between different levels of convergence reflected in the three dimensions of PA already set out in chapter 2, i.e. the why [purpose], how [features] and consequences [results] of PA. According to the convergence thesis, the increased emphasis on PA may be assumed to be associated with convergence on these PA dimensions across countries. However, instead, this research identifies distinct dominant approaches to appraisal in hospitals in Germany and the Czech Republic due to the impact of distinctive national institutional factors, further discussed in below.

In sum, proposition 1 was substantiated insofar that shared cross-national pressures were identified to have led to an increased emphasis on and use of PA. Despite the similar organisational (public hospitals) context and shared pressures for performance, this however did not result in similar PA approaches across countries regarding the character of PA. The



following part considers proposition 2 and why nursing as a profession also did not contribute towards convergence in terms of the type of PA.

## 7.2 Does a high level of professionalisation amongst nurses, on the basis of shared values and principles, lead to similar approaches to PA in different countries? (Proposition 2)

Chapter 3 argued that nursing as a profession may influence PA approaches for (hospital) nurses, depending on the degree of professionalisation reached. It was further argued that despite nuances, nursing across countries (certainly within Europe) shares many features such as e.g. its historical background, its ethos, broader (e.g. EU-level) regulation, similar types and contents of training and importantly shared attempts for further professionalisation. On this basis, it was expected that a high level of professionalisation amongst nurses, on the basis of shared values and principles, would lead to similar PA approaches across countries (proposition 2 - strong version) whereas a low level of professionalisation, in either one or both countries, would contribute toward more variation (proposition 2 - weak version) as this would imply less influence over PA.

To assess the extent to which nursing as a profession can shape PA, the current state of nursing was examined in each country regarding the educational system of nurses, professional associations and trade unions as the literature indicates that these aspects are largely indicative of the level of professionalisation, which in turn is associated with the extent to which an occupation can shape certain practices, including PA (Paauwe and Boselie, 2003).

In Germany, despite incremental advancements within nursing (e.g. establishment of first nursing chamber in one federal state), a lack of status of nursing was detected which manifests itself in the fact that nursing is regarded to have neither a united nor strong 'voice'. In the Czech Republic, important changes occurred notably regarding nurses' educational systems, spurred by the EU accession. Unlike Germany, where nurses are trained at vocational school level, in the Czech Republic general nurses must currently complete a bachelor or equivalent degree as in most EU countries. However, there are plans to effectively reverse the advancements made in this area. Furthermore, the discussion around a possible chamber has subsided due to the influential health ministry and medical chamber. Neither Czech nursing associations nor trade unions are reported to have much influence over nursing-related matters and many fear that currently a 'degradation' of nursing is taking place. In both countries nursing lacks prestige and is largely regarded as an unattractive occupation.

Overall, in both cases, the lack of a nursing chamber is significant and nursing institutions do not engage with the topic of PA and lack involvement and the scope to do so. Therefore, although nursing across the two countries shares many features, in both cases the nursing profession does not directly influence PA practices, which arguably explains why other reforms or initiatives (e.g. hospital accreditation pressures in the Czech Republic) are not as constrained by the profession, as possibly would be the case with 'stronger' or full professions. As Ferlie (1999, p. 18) has previously noted, "mass professions (such as nursing) may be more vulnerable than elite professions (such as medicine)" in many respects.

However, as suggested previously, this does not necessarily preclude the possibility of nurses influencing PA at local level by resisting certain types of PA (Murphy and Cleveland, 1995; Nayeri et al., 2005), either actively or passively (Lauer and Rajagopalan, 2002; Wilson and Nutley, 2003; Anderson, 2008). Yet, as the hospital cases indicate, nurses at the most 'passively resist' more controlling, discipline-orientated forms of PA by complying to a minimum and treating PA as a formality. Therefore, whilst similarities can be identified in terms of the extent to which nursing shapes PA, in each country the extent to which such an influence can be discerned is limited.

The key difference between the Czech and German case regarding nurses' ability to influence PA practices is that in Germany the WC, further discussed below, is influential in representing hospital staff, including nurses, and thus in moderating the impact of wider hospital pressures. Thus, nurses have some scope to indirectly influence PA through the WC, resulting in the adoption of more nurturing-orientated types of PA in German public hospitals which provide a lot of freedom to ward managers.

In conclusion, nursing as a profession lacks the scope to shape PA systems in both countries due to the similarly limited scope of influence of nursing institutions associated with lower levels of professionalisation. Hence, proposition 2 (strong version) does not hold for these countries because nurses in both Germany and the Czech Republic are not well organised professionally. Instead, the 'weak' version of proposition 2 holds since the identified lack of professionalisation creates more potential for cross-country variation, as explored in the next section.

### 7.3. Are shared pressures moderated by national institutions leading to different approaches to PA? (Proposition 3)

In chapter 3 it was discussed that the divergence perspective and institutional theory emphasise the influence of national institutions in shaping organisational practices. Specifically the VoC approach (Hall and Soskice, 2001) is comparative in nature and argues for enduring national institutional differences which in turn give rise to distinct approaches adopted by organisations, including regarding their HR practices such as PA. In applying the conceptual basis of the VoC approach, this study explored relevant national institutions in Germany and the Czech Republic, which represent distinct country classifications (i.e. CME versus emergent LME).

National institutions were indeed found to shape PA for hospital nurses in different ways in countries characterised by a different institutional setting. Two key national institutions were confirmed to be crucial, one in each country: in Germany, the WC and in the Czech Republic, the hospital accreditation system and its associated requirements. These institutions should not be regarded in isolation, given the notion of institutional complementarities (Hall and Soskice, 2001) which implies that institutions in a country tend to complement each other. For example, the role of the WC in Germany should be regarded as part of the wider employment relations system and in connection with the role of trade unions and collective bargaining. In the Czech case, the former Semashko healthcare system and the communist legacy more broadly is in part associated with the weak role of trade unions as these are viewed as remnants of the communist regime. In turn, the limited role of trade unions further feeds through to limited employee representation at local level and provides more scope for external quality assurance mechanisms to influence management practices. Country differences regarding collective bargaining arrangements has implications for the performance bonus component of PA, such that it provides a more formal scope for hospitals in Germany to use bonus mechanisms in an organised way while in the Czech Republic the centralised legally regulated system is silent on bonuses enabling a more informal and less transparent bonus system.

The following section compares in more detail how the national institutional context impacts PA for hospital nurses in Germany and the Czech Republic and re-asserts the resulting different tendencies in each country.

### 7.3.1 Distinct PA tendencies in German versus Czech hospitals

Although nursing lacks a united strong voice in both countries, it can be argued that in the German case, the WC emerged as an important national institution which compensates for the lack of voice within nursing at least to a certain extent, as WCs represent the workforce as a whole. In line with the VoC model which categorises Germany as a CME, which is characterised by, amongst other things, co-determination structures at workplace level and a higher incidence of collective and representative voice mechanisms, it was found that the WC at hospital level has a lot of scope to influence PA as it falls within its co-determination rights. In Germany, WCs may resist the implementation of PA, and often do especially more control-orientated approaches, yet in other cases they support PAs implementation whilst having the ability to continue to shape the form PA takes. The fact that the union perspective is antipathetic to performance-related bonuses is in line with previous research (e.g. Corby and White, 2003). Therefore, a clear tendency could be identified as WCs usually favour developmental 'staff discussions' and oppose more control-orientated formats of PA. Consequently, more internal ownership was found at German hospitals, with ward/nursing managers proactively utilising PA to redress the lack of nursing's influence and status at local level by encouraging more engagement via developmental forms of PA.

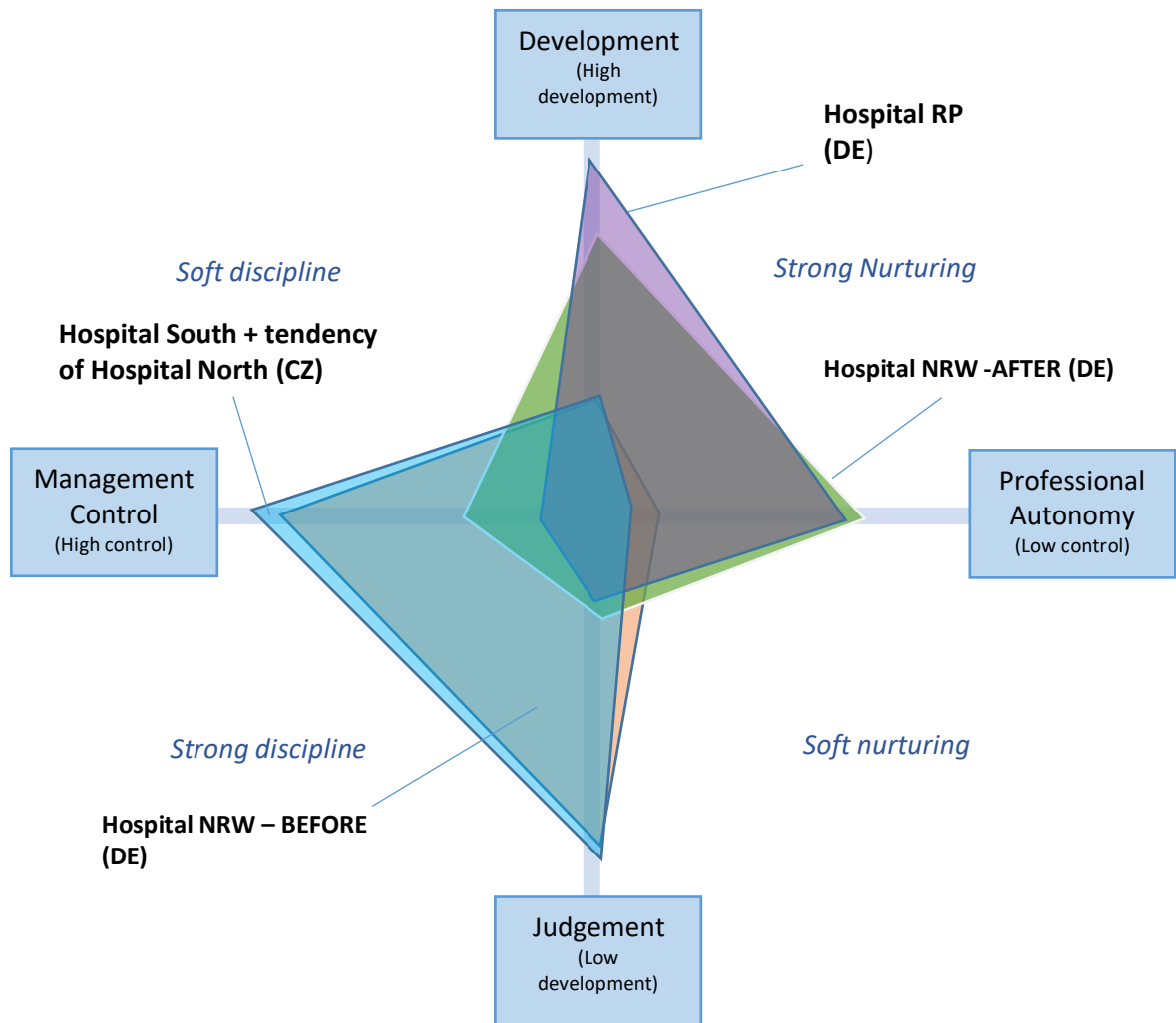
While the importance of quality management systems and the external accreditation of these systems has increased in importance in both countries, in Germany no direct link between accreditation processes and PA could be established. Conversely, throughout the Czech case the link between certification/accreditation and PA was emphasised. Here, hospitals introduce PA due to external requirements rather than because PA itself is part of the employer's strategy. Instead, PA depends on whether accreditation is part of the hospital's long-term agenda. Given broader pressures within the country to gain external hospital accreditation, a clear trend to do so can be observed. Although the appraisal form can be designed by the hospitals themselves, the tendency in Czech accredited hospitals is the use of 'performance evaluation' which implies a clear assessment and marking of certain criteria, as this is said to be required by external accreditation companies. Therefore, PA in Czech hospitals represents an externally imposed process resulting in PA systems more orientated towards judgement and control rather than toward autonomy and development which is interpreted as a 'tick box' exercise, leading to little internal ownership of the process. Nishii et al. (2006) previously highlighted the importance of attributions of the 'why' made regarding the effect of HRM practices and the differentiation of externally driven versus internally driven practices. This thesis confirms the importance of this,

and finds that this difference leads to distinct experiences of PA for nurses in Czech hospitals versus German hospitals.

#### *Connection between institutional context and workplace level findings*

The fact that German and Czech hospitals differ in their dominant approaches to PA is further confirmed by the findings of the detailed hospital-level fieldwork which allowed for a thorough examination of the 'why', 'how' and 'what' of PA. It also provided the opportunity to assess the linkages between the purpose of PA [why] and how this affects the structure of PA [how], and how all this relates to the consequences of PA. It should be noted that despite dominant approaches to PA in each country, it was also confirmed that often PA incorporates various elements. Indeed, the framework for comparison, developed in chapter 2, proved useful as it enables the illustration of different elements within one type of appraisal. For example, in relation to the hospital where a strong nurturing-orientated approach dominated, at the same time elements of judgement were found. This means that the prescriptive PA literature, reviewed in chapter 2, which promises a committed workforce via developmental forms of PA and the highly critical (i.e. radical) PA literature, which argues that PA is doomed due to its inherently controlling elements, as well as the 'ritualistic' literature, which suggests that PA is largely a ritual without any effect, oversimplify the characterisation of PA as in practice there are seldom 'pure' forms of PA. Having said that, clear tendencies prevail in both as can be seen in figure 7.1. In terms of scoring on the diagram in figure 7.1, the first stage involved that each case has been analysed by comparing the 4 dimensions and the sub-dimensions (provided in table 2.4) within the particular case. The second stage of analysis was to compare across the four cases on each dimension to guarantee consistency across cases. The clear distinct PA approaches which emerge from the hospital cases can be explained by the wider national institutional context. This section takes another look at the individual German and Czech hospital cases to show how shared cross-national hospital pressures are moderated by national institutions and to what effect.

**Figure 7.1: Framework for comparison: Germany (DE) vs. Czech Republic (CZ)**



Source: Author's own compilation

### *German case*

Based on national-level stakeholder interviews as well as primary and secondary survey data, it can be suggested that Hospital RP represents the German case best. Here, there was a general awareness that the WC would resist any other formats of appraisal other than in the form of staff discussions. This reflects the general aversion of WCs toward systems of e.g. performance related bonuses (PRBs), making the likelihood of evaluation-orientated PA systems low. Further, at this hospital it was alluded to the inherently tense relations between the employer and WC, as the nursing director, whose role falls under the employer's side (e.g. Wolf and Ostermann, 2016; Grimm, 2013), emphasised the need to manage these relations sensitively. At the same time, the nursing director expressed an understanding for the WC's view of PRBs and the

difficulty of measuring performance objectively within nursing. Therefore, this hospital adopted PA in the form of staff discussions with its main purpose described to revolve around further training and development. Apart from the employer's strategy and its relationship with the WC, the wider contextual background of nursing shortages and a lack of nurses entering the occupation contributed to the focus on this nurturing PA type in an effort to increase retention. The vocational system of nurses in Germany was furthermore highlighted as a driver for a development-orientated type of PA, since "up-skilling" is required. Particularly since no specific nursing body monitors the further development of nurses in Germany, due to a lack of a central register, this need for a developmental-orientated tool was again reiterated. Nursing staff conveyed in interviews that PA is seen as encouraging process whereby personal development goals can be set. If there was an interest from the employee to undergo further training and/or to take on additional tasks, this would also be discussed and agreed during staff discussions. Thus, appraisal could lead to widening the scope of activity and responsibility and ultimately autonomy of the individual nurse. Naturally, while some degree of judgement-making is required to provide feedback, for the most part staff discussions were conceived as developmental and nurturing. The focus on development and the consequential feelings of nurses of being valued by their organisation is furthermore reflected in the survey results, further discussed below.

The second German hospital "NRW" represents an exceptional case but also that, in the end, a tendency for development-orientated forms of PA prevails in the public hospital sector in this country. At this hospital, controversial changes to the collective bargaining agreement (TVöD) were regarded as an opportunity for the employer to pursue the implementation of individual PA linked to bonuses across the workforce. The perceived impetus for doing so was linked to the lack of pay differentiation within nursing. The WC in this case exhibited a more cooperative approach towards the employer and, after a process of consultation and communication, was willing to conclude a works agreement which provided the basic framework for the PA and bonus system. This willingness, in part, was due to the self-perceived main role of the WC to preserve jobs and terms and conditions. Given the wider trend in Germany of hospital privatisation, it was argued that the WC's cooperative stance would be eventually more beneficial for its workforce. However, the individual-based PA system (linked to bonuses) led to unintended consequences. Nurses reported an increase in competition within their teams which led to an atmosphere of resentment, a perceived intensification of monitoring and control as well as feelings of unfairness regarding the criteria used. Specifically managerial staff also noted the time and effort needed to implement this system. Despite these largely negative

consequences expressed by nurses, they did not actively resist, but arguably resisted 'passively' as they solely grudgingly accepted and complied with the system.

The impetus for abandoning this system occurred after these practical limitations and inefficiencies of the system emerged. The change also coincided with the arrival of a new nursing director who transformed the individual-based PA system into team-based targets and bonuses. Ward managers were reportedly able to communicate their frustrations to the new nursing director who, with the support of the WC and the rest of the hospital management, could implement the new system. Also, the works agreement concluded with the WC was key in this regard as it provided the scope for such changes to occur. The new system of team targets and bonuses involves the conduction of regular team-days which was said to be contributing first and foremost to the development of a team-spirit and better teamwork. According to those nurses interviewed, during 'team-days' targets and their implementation strategy can be openly discussed, associated tasks and responsibilities mutually agreed and the overall position of nursing at the ward strengthened.

An interesting finding at Hospital NRW was a lack of awareness of the continuing existence of the performance bonus, albeit now team-based. The general sentiment of those interviewed was that regardless of whether bonuses are paid or not, it does not matter as long as payments are not differentiated any longer and because the amount is perceived as low. The importance of the size of a bonus has been noted elsewhere (Perkins et al., 2016). Despite being unaware of this aspect in many cases, team performance is formally evaluated and rewarded accordingly. As such, the new instrument of team-based appraisal can be identified as constituting elements of judgement and management control however mixed with some discretion over how to achieve set targets. Additional goals can also be freely set in participation of all nurses. Task allocations are also commonly agreed upon. This type of appraisal moreover features facets of 'development and nurturing' although this relates more to the team rather than the individual nurse. Besides team-based targets and bonuses, the abolition of the former system was also intended to lead to the adoption of individual staff discussions with nursing staff with an emphasis on personal development. The findings suggest that because staff discussions are not obligatory, in practice ward managers are not likely to conduct them in a regular or structured manner. Where staff discussions do occur, the experience of staff tends to resemble the situation of hospital "Rheinland-Pfalz": an overall non-threatening, positive exchange between the supervisor and staff with attention given to the personal development and growth of the



individual nurse. Hence, overall, German public hospitals tend to adopt strongly nurturing types of PA, as reflected in figure 7.1.

### *Czech case*

The Czech case is more straightforward in that there is a consistent association between external hospital accreditation and PA. In line with the general picture in the Czech Republic, the reason for having introduced or planning to introduce PA in the form of 'performance evaluations' was the same in both Czech hospitals investigated. The only difference was that they were at different stages in terms of implementation. At hospital South, the main reason for introducing PA was clearly related to its certification and accreditation processes across the hospital. There was a shared understanding amongst nursing staff that PA is a practice which must be conducted due to external requirements and as such it is a generally accepted practice. Again, this highlights the importance of internal versus external attributions of the why (Nishii et al. 2006) made, an aspect the PA literature largely ignores. Nevertheless, despite this acceptance and general feelings of indifference towards the system due to a lack of internal ownership of the system, nurses have become discontented with the system. For nurses, PA represents a control mechanism which is associated with increased monitoring and judgement-making. Relatedly, nurses overwhelmingly tended to not feel valued as a result of PA but rather the opposite, namely belittled. Consequently, nurses can be observed to 'passively resist' the practice in the sense that nurses comply but only to a minimum extent whilst grudgingly accepting the system and treating it as only a formality. This is reminiscent of the 'appraisal disdain' identified by Healy (1997) regarding schoolteacher appraisal. However, this has little impact on the basic character of PA which continues to be predominantly judgement and control-orientated.

The second Czech hospital case, Hospital North, is not yet accredited hospital-wide but intends to seek accreditation in coming years. Currently, solely those units which must be (individually) certified or accredited by law are also certified/accredited at the hospital. This applies to more 'technical' units of the hospital such as its laboratories. At these specific units, an annual, formal and structured PA in the form of 'performance evaluation' is in place. The appraisal forms are similar in nature as those used in Hospital South. The remaining wards which are particularly relevant to nursing staff are not under obligation to conduct PA at all, at least for now. Ad-hoc discussions with staff can be conducted where regarded as necessary, however is rarely done in practice and only when specific problems arise. It was expressed during interviews that it is feared that once further accreditation processes take place and PA will therefore be introduced across the hospital, appraisal will become just a formality. Again, it is suggested that since the

practice of PA will be attributed to external requirements, PA will be accepted by the workforce and indeed conducted, however solely to comply with these requirements to the necessary minimum level. Overall, given that the reason for introducing PA is the same as in Hospital South, the character of PA will likely be similar, and already similar outcomes are expected. Considering the framework for comparison (see figure 7.1), appraisal in these instances can be categorised as primarily concerned with judgement and further ('quality') control rather than being developmental or nurturing in nature.

#### *German vs. Czech hospital cases*

The fact that German and Czech hospitals adopt distinct dominant approaches to PA and that these lead to different consequences for nurses is reflected in the survey data collected at the Czech and German hospital case sites. Survey questions were based on the most relevant questions used in the British NHS staff survey. After excluding all non-applicable cases, first, a series of Chi-square Tests were conducted regarding the PA-related questions of the survey.

Survey results corroborate the findings of the qualitative research phase in terms of German hospitals adopting more development-focused PA systems in comparison to Czech hospitals. As shown in table 7.1, the results indicate that there is a statistically significant relationship between the country of the hospital and whether any training, learning or development needs were identified as part of appraisal [ $X^2(1, N=291)=8.078, p<.001$ ], such that there was a significantly higher proportion of participants who indicated that such needs were identified were found in the German hospital cases (75.6%) compared with the Czech hospital cases (58.2%). This confirms that on the whole, PA in German hospitals is more orientated towards training and development.

**Table 7.1 Comparison of Survey results: Germany vs. Czech Republic (In %)**

Question	Hospital cases	Yes (%)	No (%)	Can't Remember (%)	$\chi^2$
Did PA help you to improve how you do your job?	German hospitals	74.7	25.3	-	.805
	Czech hospitals	69.5	30.5	-	
Did PA help you agree clear objectives for your work?	German hospitals	86.5	13.5	-	1.738
	Czech hospitals	80.1	19.9	-	
Did PA leave you feeling that your work is valued by your organisation?	German hospitals	77.3	22.7	-	22.757**
	Czech hospitals	47.0	53.0	-	
Were any training, learning or development needs identified?	German hospitals	75.6	24.4	-	8.078**
	Czech hospitals	58.2	41.8	-	
Did your manager support you to receive this training learning and development?	German hospitals	95.1	4.9	-	1.672 <sup>f</sup>
	Czech hospitals	98.4	1.6	-	

\*\*significant at 99% level, \*significant at 95% level

Table 7.1 also shows a statistically significant relationship between the country of the hospital and whether nurses feel that their appraisal left them feeling valued by their hospital/organisation [ $\chi^2(1, N=288) = 22.757, p<.001$ ]. A significantly higher proportion of participants who felt valued as a result of PA were found in German hospitals (77.3%), compared to the Czech hospitals (47.0%). In the Czech Republic, just over half of those who said that they have had an appraisal in the last 12 months felt that their appraisal has *not* left them feel valued by their organisation (53.0%), compared to 22.7% in Germany. This is an important finding because it corroborates the findings of the qualitative research phase which indicated that national institutions do indeed give rise to distinct national models of PA, which in turn affects the way in which nurses perceive PA. The survey findings confirm that PA is viewed and experienced by nurses in different ways in different countries. In the case of Germany, where the orientation is more towards training and development, nurses feel valued as a result of PA and in the Czech Republic, where the orientation is less on further development, nurses do not. The general sentiment of these findings is clear and in line with the PA literature which suggests that control and discipline-orientated PA systems associated with increased monitoring, such as PA in the form of performance evaluations in the Czech case, are negatively perceived especially in the context of knowledge-based occupations such as nursing, and that feelings of resentment and alienation are likely to occur (Simmons and Eades, 2004, p. 155). Interview data together with the survey results suggest that as a result of PA nurses do not feel valued or like their work is recognised in the Czech case. In comparison, in the German case where PA, mostly in the form of staff discussions, is geared towards nurturing staff via training and development, as also

reflected in these survey findings, nurses tend to feel more valued overall and as if their work is being recognised.

This is further backed up by findings on the general perceptions of nursing staff at their respective hospitals. In relation to the question which asked participants to rate their satisfaction levels on a 5-point scale, firstly in terms of the statement ‘The recognition I get for good work’, results of an independent sample t-test,  $t(488) = 3.606$ ,  $p < .001$ , identified a significant difference in mean responses between Czech and German nurses. More specifically, German nurses were on average more satisfied (mean=3.47[SD=1.129]) than Czech nurses [mean=3.07[SD=1.034]] (see table 7.2). Secondly, results of the independent-samples t-test for the statement “The extent to which my organisation values my work” indicate a significant difference [ $t(487) = 3.608$ ,  $p < .001$ ] in scores between Czech and German nurses. German nurses are more satisfied (mean=3.51[SD=1.141]) than Czech nurses [mean=3.12[SD=1.018]] with respect to the extent to which their organisation values their work (see table 7.2). These findings indicate that it would be reasonable to suggest that nurses’ perceptions regarding PA affects general satisfaction levels in terms of the recognition they receive more broadly.

**Table 7.2 Survey Results: Germany (DE) vs Czech Republic (CZ)**

	DE or CZ	N	Mean	SD	p-value
The recognition I get for good work	DE	124	3.47	1.129	<.001
	CZ	366	3.07	1.034	
The support I get from my immediate manager	DE	124	3.81	.925	.086
	CZ	363	3.65	.875	
The freedom I have to choose my own method of working	DE	125	3.78	.949	.007
	CZ	365	3.53	.853	
The support I get from my work colleagues	DE	124	3.97	.816	.017
	CZ	368	3.77	.797	
The amount of responsibility I am given	DE	125	4.08	.839	<.001
	CZ	365	3.70	.727	
The opportunities I have to use my skills	DE	125	3.96	.837	<.001
	CZ	365	3.56	.835	
The extent to which my organisation values my work	DE	123	3.51	1.141	<.001
	CZ	366	3.12	1.018	
My level of pay	DE	123	2.69	1.229	.163
	CZ	368	2.52	1.141	

Table 7.2 shows a further set of independent samples t-tests in terms of general satisfaction levels. The consideration of general satisfaction levels is relevant because, although these survey question were not directly related to PA, the results indicate that PA may have wider-reaching implications. Table 7.2 shows, that regarding the statement “The freedom I have to choose my own method of working” [ $t(488) = 2.686$ ,  $p = .007$ ] a significant difference in mean scores between Czech and German nurses was found, so that German nurses are satisfied to a greater extent

(mean=3.78[SD=.949]) than Czech nurses [mean=3.53[SD=.853]] with respect to this item. Results for the statement “The support I get from my work colleagues” [t(490)= 2.386, p=.017] showed a significant difference in scores for German (mean=3.97[SD=.816]) and Czech nurses [(mean=3.77[SD=.797])] in that German nurses tend to be more satisfied with the support they get from colleagues. The independent-samples t-test for the statement “The amount of responsibility I am given” also [t(488)= 4.826, p<.001] shows a significant difference in scores between Czech and German nurses. German nurses are more satisfied (mean=4.08[SD=.839]) than Czech nurses [mean=3.70[SD=.727]] with respect to the amount of responsibility they are given. Furthermore, the independent-samples t-test for the statement “The opportunities I have to use my skills” shows a significant difference [t(214.547)= 4.597, p<.001] in scores between Czech and German nurses. German nurses are more satisfied (mean=3.96[SD=.837]) than Czech nurses [mean=3.56[SD=.835]] with respect to the opportunities they have to use their skills. Overall, these findings indicate that nursing staff in the German hospitals feel they have more freedom, appropriate levels of responsibility, and opportunities to use their skills. This resonates with the interview findings because it was suggested that in Germany, PA in the form of staff discussions but also in the form of team-days (i.e. team discussions), are used to mutually discuss tasks and responsibilities. In comparison, PA in the Czech Republic largely does not deal with these aspects.

The results of the independent-samples t-test for the item “My level of pay” [t(489)= 1.397, p=.163] showed no significant difference in scores for German (mean=2.69[SD=1.229]) and Czech nurses [(mean=2.52[SD=1.114])]. Both groups tend to be dissatisfied with their level of pay. This may be explained by the general sense that nurses feel their occupation as a whole is not appreciated and not sufficiently remunerated. This finding may thus connect to the wider issue of the lack of status of nursing and its low level of professionalisation.

Moreover, the t-test for the item “The support I get from my immediate manager” [t(485)= 1.723, p=.003] identified no significant difference in mean scores between Czech and German nurses (see table 7.2). In a similar vein, regarding statements concerned with the immediate manager and the extent to which nursing staff either agrees or disagrees, no significant differences in the average scores of the two groups were found (see table 7.3), except for the statement ‘My manager gives me clear feedback on my work’, where results show a significant difference [t(489)=3.192 p=.002] in scores such that German nurses tend to agree more (mean=3.97[SD=.941]) than Czech nurses [mean=3.66[SD=.912]]. Thus, while in general the relationship between nursing staff and their immediate manager is usually equally good in both

countries, in terms of feedback which has implicit links with the type of PA adopted, German nurses agree more due to the more feedback-orientated staff discussions or even team-level discussions in German hospitals.

**Table 7.3 Survey results: Germany (DE) vs Czech Republic (CZ)**

	DE or CZ	N	Mean	SD	p-value
...encourages those who work for her/him to work as a team	DE	125	3.96	.954	.055
	CZ	367	3.78	.892	
... can be counted on to help me with a difficult task at work	DE	125	3.99	.980	.262
	CZ	367	3.89	.892	
...gives me clear feedback on my work	DE	125	3.97	.941	.002
	CZ	366	3.66	.912	
...asks for my opinion before making decisions that affect my work	DE	124	3.73	1.069	.094
	CZ	367	3.55	.962	
...is supportive in a personal crisis	DE	123	3.89	1.039	.082
	CZ	366	3.71	1.023	

Further differences emerged in terms of general perceptions at the hospitals. Firstly, as table 7.4 shows, the results of the independent sample t-test,  $t(484)=4.654$ ,  $p<.001$ , identified a significant difference in mean responses between Czech and German nurses, in terms of the extent to which they agree that they have clear, planned goals and objectives for their job. German nurses agreed to a greater extent (mean=4.25[SD=.706]) than Czech nurses [mean=3.86[SD=.846]]. Secondly, the independent-samples t-test for the statement “I always know what my work responsibilities are” [ $t(493)=2.695$ ,  $p=.007$ ] identified a significant difference in mean scores between Czech and German nurses. More specifically, German nurses agreed to a greater extent (mean=4.38 [SD=.716]) than Czech nurses [mean=4.19[SD=.667]], although both groups of nurses tend to agree. Thirdly, the independent-samples t-test for the statement “I am trusted to do my job” [ $t(492)= 4.900$ ,  $p<.001$ ] identified a significant difference in mean scores between Czech and German nurses. German nurses agreed to a greater extent (mean=4.26[SD=.731]) than Czech nurses [mean=3.88[SD=.764]]. Again, although these statements were not explicitly related to PA, it appears that not only do German nurses tend to agree more that they have clear goals and a clear understanding of their responsibilities but also, somewhat related to the notion of feeling valued, they feel a general sense of trust provided to them. Interview data confirms that PA contributes toward these results.

**Table 7.4 Survey results: Germany (DE) vs. Czech Republic (CZ)**

	DE or CZ	N	Mean	SD	p-value
I have clear, planned goals and objectives for my job	DE	124	4.25	.706	
	CZ	362	3.86	.846	<.001
I always know what my work responsibilities are	DE	125	4.38	.716	
	CZ	370	4.19	.667	.007
I am trusted to do my job	DE	125	4.26	.731	
	CZ	369	3.88	.764	<.001

The final set of questions asked participants in how far they agree with statements about team working and were related to the group of people that they work with most closely. This question asked participants to rate the extent to which they agree or disagree on a 5-point scale (see table 7.5).

**Table 7.5 Survey results: Germany (DE) vs. Czech Republic (CZ)**

	DE or CZ	N	Mean	SD	p-value
Team members have a set of shared objectives	DE	119	4.13	.869	.003
	CZ	298	3.87	.784	
Team members often meet to discuss the team's effectiveness	DE	121	3.74	1.160	.032
	CZ	292	3.49	1.007	
Team members have to communicate closely with each other to achieve the team's objectives	DE	121	4.19	.809	.009
	CZ	294	3.97	.763	

Results of the independent sample t-test,  $t(415) = 2.966$ ,  $p = .003$ , showed a significant difference in mean responses between Czech (mean=3.87[SD=.784]) and German nurses (mean=4.13[SD=.869]) in terms of the extent to which they agree that team members have a set of shared objectives, so that German nurses tend to agree more with this statement. Secondly, the independent-samples t-test for the statement "Team members often meet to discuss the team's effectiveness" [ $t(411) = 2.157$ ,  $p = .032$ ] identified a significant difference in mean scores between Czech and German nurses. More specifically, German nurses agreed to a greater extent (mean=3.74[SD=1.160]) than Czech nurses (mean=3.49[SD=1.007]). Results of the independent sample t-test,  $t(413) = 2.630$ ,  $p = .009$ , showed a significant difference in mean responses between German (mean=4.19[SD=.809]) and Czech nurses (mean=3.97[SD=.763]), in terms of the extent to which they agree that team members have to communicate closely with each other to achieve the team's objectives. Again, although this question was not directly linked to PA, in conjunction with the interviews it can be concluded that PA is more nurturing in nature in the German cases and has positive implications for team work in terms of setting shared objectives and communicating more closely in relation to these objectives, particularly in Hospital NRW, whilst stricter discipline-orientated forms of PA create a less conducive atmosphere in relation to those aspects.

In sum, proposition 3 holds as both interview and survey data confirm that there are important differences between the Czech and German case regarding the dominant approach to PA taken. These differences in turn can be attributed to key national institutional factors. In the Czech Republic accreditation requirements largely determine the type of PA adopted, while in Germany the key variable is the WC which has implications for how PA is practiced. This has implications for the 'why', 'how' and consequences of PA.

### 7.3.2 Scope for within-country discretion in national models for PA

Chapter 3 highlighted that it is important to take the potential of within-country variation into account because despite national institutional constraints, there may still be scope for strategic choice for managers and their organisations (e.g. Boon et al., 2009). As organisations' internal dynamics vary, so might their responses to institutional pressures albeit within certain parameters (e.g. Greenwood and Hinings, 1996). Thus, it was suggested that there might still be "strategic space" (Keizer, 2011, p. 46) for hospitals to adapt their PA systems, giving rise to some variations within countries as well. Although the focus of the VoC model relates to national differences, it was identified that in line with this model it could be argued that there is more scope for within-country variation in LMEs rather than CMEs because CME countries like Germany are more tightly regulated especially in terms of employment relations than (emergent) LMEs.

This study identified that in both countries there is scope for *some* within-country variation via national institutions despite clear dominant approaches to PA in each country. In Germany, depending on the particular ideology of the hospital's WC and its relationship with management, and the employer's own strategy, there is potential for a variation albeit within set parameters set by the legal context (e.g. collective bargaining agreement). This is broadly in line with research findings by Greer et al. (2010) who identified that employer-works council relations may vary between hospitals. Still, WCs tend to take a similar stance toward PA and as such WCs tend to set the parameters for any PA system, given their strong co-determination rights, so that in public hospitals 'developmental' and 'nurturing' PA dominates in Germany.

In the Czech Republic, hospital WCs can also be established but they are different in nature compared to German ones. Only recently WCs are allowed to be formed on a voluntary basis alongside trade unions active in hospitals, and have an overall limited role due to limited consultation and information rights. Hence, in Czech hospitals it is the sole decision of the hospital's management whether to adopt appraisal and what form appraisal takes. This decision in turn was found to be informed by the requirements of external of accreditation. Despite the



clear tendency in the Czech case to adopt PA in the form of performance evaluations which implies a more judgement/control-orientated version of PA, there is scope for variation as it is ultimately up to hospital management to decide which form PA takes. Indeed, considering the broader findings of the Czech case, it was found that some hospitals go even further and relate PA to the competencies nurses have. There would be scope to adjust appraisal in other ways too, however, again, in practice the performance evaluation type dominates due to the general guidelines by accreditation bodies which, it is argued, prescribe an appraisal system of this sort.

Overall, the findings of this study suggest that whilst in both country cases there is at least some scope for PA variation, in comparison, the German case exhibited more variation. This is because individual WCs may differ from each other in the way in which they handle requests by the hospital management to introduce particular types of PA, resulting in different PA approaches. The potential scope for different approaches taken by WCs in Germany is greater than the permissiveness of accreditation requirements in the Czech Republic regarding the form PA takes, although WCs in public hospitals tend to take a similar stance in Germany. Still, the fact that in practice more variation was identified in the German case contrasts with the VoC model which would predict more variation in LMEs (i.e. Czech Republic) rather than CMEs (Germany) (Farndale et al., 2008). Nonetheless, even in the German case an overall clear tendency in relation to PA approaches could be identified. The table below summarises the key points of PA in each hospital case, including the type of PA adopted, the key decision-makers and drivers for the introduction of PA as well as the three dimensions of PA i.e. in terms of the why, how and consequences of PA.

**Table 7.6: Summary of PA at hospital cases in Germany & Czech Republic**

	Germany		Czech Republic	
	Hospital "RP"	Hospital "NRW"	Hospital South	Hospital North
<b>Tradition of PA?</b>	Long-standing	No (Short)	Yes (Medium)	No
<b>Type of PA</b>	Staff discussions	From individual appraisal & bonus to team targets & bonus (+ sporadic staff discussion)	Performance evaluation	Now: unstructured, ad-hoc. Future: Performance evaluation
<b>Key decision-maker</b>	Employer + works council	Employer + works council	Employer	Employer
<b>Impetus for introduction/change</b>	Employer strategy informed by national context (nursing shortage; nurses' training system)	1) Employer strategy informed by changes to collective agreement 2) change in nursing director, informed by feedback of nursing managers	Hospital certification/ accreditation	Hospital certification/ accreditation
<b>Why PA</b>	Staff development & nurturing	Now: Target-orientated working + team-work + individual staff development	Comply with demands of certifiers	in preparation for accreditation
<b>How of PA</b>	Long-term orientation; intrinsic rewards; coaching; development plan; high levels of participation; within-person comparison	<u>Now</u> : focus is long-term on team development; intrinsic and extrinsic rewards; high levels of participation; within-team comparison	Evaluation of past performance against set criteria; informally related to bonus (un-transparent bonus system) minimum concern for further development; no employee participation	Not applicable for nursing staff as yet but expected like Hospital South in future
<b>Consequences of PA</b>	Positive experience for nurses: Personal development, expansion of skills etc.	Team development + nurturing of a team spirit. Little use of staff discussion but positive for nurses when used.	General acceptance but dissatisfaction with system. Tick-box exercise, no internal ownership	Not applicable. Expected: tick-box exercise, no internal ownership

Despite having identified prevalent country differences in this study, including in the survey results, when looking at the more detailed distribution of survey responses (see appendix 3), it is interesting to note some of the subtle differences between the individual hospital cases. In terms of the question if PA helps to improve how one does ones' job, a higher percentage replied yes at Hospital RP (76%), where staff discussions have a long tradition, than at Hospital NRW (67%) where there had been recent changes to the PA system (although the small n for hospital NRW should be noted; n=12). In the Czech case, less participants replied yes to this question in

Hospital South (67%) where PA in the form of performance evaluation occurs, than in Hospital North (75%) where no formal PA is yet in place.

Similarly regarding the question if PA helped to agree clear objectives, at German Hospital RP, where staff discussions occur, and at Czech Hospital North, where no formal staff discussions occur, a higher percentage of participants answered 'yes' (Hospital RP: 88%, Hospital North: 87%) than in the Czech case where formal performance evaluations are in place or in the German case where there was a recent move from performance evaluations to more developmental team-discussions and staff discussions (Hospital South: 77%; Hospital NRW: 75%).

This general picture can be found in the more detailed results of the remaining survey results as well (see appendix 3) insofar that the most satisfied nurses can be found in Hospital case RP, where there is a long-standing tradition of nurturing staff discussions. All this shows firstly, that the individual hospital cases all indicate some differences in terms of particular nuances of PA even within a country, despite a clear dominant approach to PA in each country. This means that potential variations within countries should not be ignored when doing country-level analysis. Secondly, the findings show that nurses tend to respond to certain types of PA in similar ways regardless of the country in question, with more positive attitudes associated with nurturing types of PA and less positive attitudes with discipline-orientated PA systems. This tells us that with respect to PA, the different levels of convergence as reflected in the different dimensions of PA (i.e. the 'why', 'how' and consequences) are indeed connected at least in the context of nursing and public-sector hospitals.

In sum, *some* within-country variation can be detected in public hospitals in both countries regarding PA for nurses. Hence, there is some discretion for national models of PA to vary. However, the extent to which there is scope for variation depends on the parameters set by the national institutional context. In the Czech Republic, accreditation requirements largely set the parameters for PA in hospitals. In Germany, the collective bargaining agreement provides the parameters for the use of performance-related bonuses in PA, while WCs determine the format of PA.

## 7.4 Summary

This chapter reflected on the German and Czech case in the light of the research question in terms of how national institutional factors shape approaches to PA for hospital nurses and directly compared the two country cases. Furthermore, it directly addressed the propositions established in chapter 3. To sum up, the findings of this study show that there are indeed shared, cross-national pressures and a concomitant increased emphasis on organisational as well as individual performance which in turn has led to an increased importance and use of PA for nurses in German and Czech hospitals. However, these common cross-national pressures have not led to similar PA approaches across countries. Instead, national institutions are central in shaping PA practices in the hospital sector which leads to different approaches to PA. The overall tendency in Germany is to adopt appraisal in the form of developmental, nurturing staff discussions due to the WCs' influence while in the Czech Republic external hospital accreditation requirements propel hospitals to adopt PA in the form of performance evaluation. These national institutions have such traction because nursing in both countries can be identified to lack influence and nursing-related institutions cannot be observed to actively engage with the topic of PA in an impactful way (e.g. via professional associations). This further contributes to the findings of variation since nursing as a profession lacks the ability to shape PA. In Germany, the WC compensates this to some extent and enables nurses to indirectly influence PA. Despite distinct dominant approaches in each country, within-country variations are possible. However, the scope for variation is related to the parameters national institutions set. As WCs in Germany may differ from one another, so can PA approaches. Similarly, the extent to which hospitals comply to accreditation requirements may vary in the Czech Republic, including in terms of PA, however depending on the discretion provided by accreditation requirements.

## Chapter 8: Conclusion

### 8. Introduction

This final chapter summarises the premise of this research and provides a brief review of the thesis. It incorporates key findings and highlights this study's contribution which centres primarily on the PA literature and also wider debates around convergence vs. divergence and the importance of context in HRM. Furthermore, this chapter offers policy recommendations. Finally, limitations of this study and directions for future research are considered.

#### 8.1 Overview and contributions of the thesis

Chapter 1 introduced the background of the study. It was shown that hospitals across countries are under increasing pressures, including financial, demographic and accountability pressures, which has increased the emphasis on performance at the organisational level, evident in the drive for performance management (e.g. OECD, 2011; Galetto et al., 2012; Pollitt and Bouckaert, 2004). This thesis was concerned with the extent to which the general pressure for organisational performance has in turn affected HR practices and individuals by focusing on the practice of PA. The research question set out was whether these pressures have led to similar PA approaches across countries or, alternatively, if and how national institutions shape PA and what consequences PA has for those involved. The thesis focused on (general) nurses because they are the largest occupational group in healthcare and their role has important implications on patient outcomes (Stone et al., 2011).

The starting point of chapter 2 was that much of the PA literature is prescriptive in nature and defines PA narrowly. Only more recently has the concept of PA broadened and become to be understood as an important dimension of PM, indicating a variety of potential purposes for PA in practice (e.g. Fletcher, 2001; DeNisi, 2000; Wilson and Western, 2000; Armstrong, 2009; Decramer et al., 2012; DeNisi and Smith, 2014; DeNisi and Murphy, 2017). Chapter 2 engaged with the PA literature and distinguished between dominant perspectives: firstly, the 'traditional perspective' of PA, secondly, the 'radical critique' of PA and finally, the perspective which views PA as a ritualistic practice (see e.g. Bach, 2005, 2013; Winstanley and Stuart-Smith, 1996; Prowse and Prowse, 2009; McGivern and Ferlie, 2007). The traditional stream of PA literature is mainly concerned with how to design PA systems effectively (e.g. Boswell and Boudreau, 2002; Wilson and Western, 2000; Murphy and Cleveland, 1995). The second strand regards PA as an inherently controlling and ethically problematic tool (e.g. Newton and Findlay, 1996; Healy, 1997; Townley, 1989; 1993a; 1993b; Grey, 1994; Coates, 1994; McGivern and Ferlie, 2007). The

final perspective suggests that PA is essentially a ritual and not impactful whatever form it takes (Barlow, 1989; Armstong and Murlis, 1998; McGivern and Ferlie, 2007; Chamberlain, 2010).

These perspectives were deemed useful in highlighting the main tensions in relation to PA, namely between 'judgment vs development' and 'control vs autonomy', and in providing an insight into the potentially distinct character and associated purposes of PA. However, this thesis argued that neither of these perspectives addresses how macro-level factors shape PA and the degree of similarity or variation in PA practices across countries because the institutional context is beyond the scope of many studies on PA (DeNisi and Pritchard, 2006; DeNisi and Smith, 2014; Kline and Sulsky, 2009; DeNisi and Murphy, 2017) due to the excessive focus on micro-level issues (e.g. Whiting et al., 2008; Ferris and Treadway, 2012; Haines III and St-Onge, 2012) and lack of comparative research (e.g. Levy and Williams, 2004; Markoulli et al., 2016; DeNisi and Murphy, 2017), especially in the public sector (Wang et al., 2017).

### 8.1.1 PA typology

This thesis sought to advance the PA literature by adopting a broader perspective and by exploring how PA is sensitive to macro-level factors stemming from the national institutional context. To do this, a typology for comparative purposes was developed and presented in Chapter 2, as this is currently lacking in the PA literature yet a necessary foundation for exploring PA in context. Indeed, this study contributes conceptually to the PA literature by providing an analytical tool by which to classify and explore different types of PA and illustrate the degree of variation between PA approaches which may be utilised in future comparative PA research. The framework draws on important dimensions raised in the wider PA literature but does not seek to classify the contributions it draws on. Rather, the framework developed in this thesis establishes four 'ideal' types of PA and, importantly, also integrates the possibility of 'hybrid' forms of PA. It is based on and configures fairly generic questions in relation to PA in a substantive format: i.e. the 'why', the 'how' and the consequences of PA.

In applying the framework to the study at hand, it was demonstrated that these elements of PA are indeed connected, as implied by the framework, i.e. the main purpose ['why'] of PA has implications for how PA operates ['how']. This in turn influences the way in which nurses perceive and react to PA. In Germany, the tendency in public sector hospitals is to adopt 'strong nurturing' types of PA which are characterised by the main purpose of development. In turn, the structure of PA is characterised by high levels of participation and professional discretion alongside a long-term orientation. Nurses react to such nurturing PA systems positively as they engage with their own professional development, have the scope to increase their competency

levels and, generally, feel more valued due to PA, as both interview and survey data showed. In Czech hospitals, discipline-orientated types of PA dominate. Here, the main purpose of PA is associated with checking and controlling staff performance to fulfil external accreditation requirements. PA is thus more short-term orientated and involves the grading of performance against a pre-determined set of criteria with little to no scope for participation. Consequently, nurses would only engage minimally with the PA process and generally feel less valued due to PA. The research findings thus show that the different PA dimensions are linked. The general premise and potency of the framework has therefore been confirmed and established.

Moreover, the framework proved particularly useful to illustrate that one specific PA system may often constitute elements of different 'ideal' PA types to varying degrees, as confirmed by the research findings. The established framework emerged as a useful tool to depict and capture these various combinations yet overall distinct PA approaches. For example, even development-orientated types of PA were found to have elements of 'judgement' while more control/discipline-orientated approaches included slight elements of development by e.g. including this aspect as one of the criteria assessed in the PA process. This indicates that both the prescriptive and 'radical' PA literature are too simplistic in their approach. The typology integrates these perspectives and acknowledges that despite recommendations of separating distinct purposes of PA (e.g. Murphy and Cleveland, 1995; Wilson and Western, 2000; Boswell and Boudreau, 2002), in practice there are various, at times competing, purposes PA may pursue which means that there are a range of different forms it can take and outcomes it can have. The PA typology thus represents a key contribution because it enhances our understanding of different versions of PA and because it is suited to explore the degree of similarity and variation of PA across settings.

### 8.1.2 Convergence-divergence paradigms

Having developed an analytical tool for comparison, Chapter 3 engaged with debates around convergence and divergence which represents the theoretical axis of this thesis. The key theoretical question of this thesis was how the convergence and divergence paradigms relate to PA. Strong arguments on both sides were identified. To recap, the convergence paradigm suggests that organisations across countries are adopting increasingly similar practices in response to shared cross-national pressures (e.g. Kerr et al., 1960; Giddens, 1990; Kerr, 1983; Kidger, 1991; Huo, et al., 2002; Gooderham et al., 1999; Tayfur, 2013). Thus, firstly, a strong case was made for sectoral-based PA convergence due to shared pressures for quality and efficiency. In particular, it was argued that shared, cross national pressures on healthcare systems lead to

an increased emphasis on performance and in turn use of PA (*proposition 1*). Secondly, given the focus on nursing, the professionalisation debate was raised on the basis of which it was argued in *proposition 2* that occupation-based PA convergence could also be expected, provided that nursing has achieved sufficient levels of professionalisation across countries to be able to influence PA ['strong' version] (Boselie et al., 2002). However, if the level of professionalisation is low in either one or both countries, it was argued that this would instead contribute to PA divergence as other country-specific institutions have more scope to moderate the impact of cross-national pressures in unique ways ['weak' version].

The divergence perspective argues for persisting variation due to national institutions (e.g. Powell, 1998; Whitley, 1999). These notions are reflected in institutional theory and the VoC model (Hall and Soskice, 2001) wherein institutional settings are regarded as relatively stable and as moderating cross-national pressures in distinct ways. On this basis it was expected that shared pressures are moderated by national institutions leading to different PA approaches (*proposition 3*).

This thesis took these debates forward by examining the degree of similarity and difference in relation to PA. Thereby this thesis sought to challenge the generic models of PA by embedding PA in its context, particularly the national as well as sectoral context, and by investigating the role of national institutions in shaping PA in the healthcare sector. Despite the vast PA literature, the wider context within which PA systems are created and practiced has been largely neglected to date (e.g. DeNisi and Murphy, 2017; Djurdjevic and Wheeler, 2014). This relates to wider issues in the HRM literature, regarding the lack of an appreciation of the wider context and national differences (e.g. Farndale et al. 2008; Meyer and Hammerschmid, 2010; Brookes et al., 2014; Markoulli et al., 2016; Poor et al., 2011).

Chapter 4 demonstrated the value of adopting a mixed-method comparative case study design to address the research questions and propositions. Mixed-method research is highly advocated as this is currently lacking in this area and because it allows for a holistic understanding of the phenomenon under investigation (Cooke et al, 2017; Apospori et al., 2008). Chapter 5 and 6 presented the findings of the German and Czech case respectively. In each case, the national context was explored, including wider hospital pressures, the status of nursing, and the institutional context in terms of external quality assurance and employment relations systems in healthcare. Each chapter identified the prevalence of certain PA types in the hospital sector and how the national context relates to this. Individual hospital cases, two in each country, were



examined in depth using the developed PA typology, and how national factors impact on PA was assessed. Chapter 7 addressed the specific propositions by directly comparing both cases.

The following two sections highlight the new insights this thesis gained regarding convergence vs. divergence in relation to PA. The key conclusion is that convergence is limited to certain aspects, and that the findings of this research show striking features of divergence. This thesis therefore demonstrates the value of adopting an institutional perspective (Brookes et al., 2011; Maley, 2013) in PA research.

### *Convergence*

This thesis substantiates that similarities in terms of shared hospital pressures contributes to an increased prevalence of PA across countries. This came through most strongly in the Czech case because hospital competition has led to an increased importance in hospital accreditation which in turn is linked to the increased adoption to PA. In Germany, similar pressures were identified in terms of efficiency and quality which is associated with an increased up-take of PA according to interviewees and as backed up by secondary survey data. Particularly in a context of nursing shortages it was argued here that the PA has become more important in order to manage and ensure adequate performance levels.

Secondly, convergence was identified regarding the way in which nurses react to certain types of PA across countries. At the outset it was argued that there is evidence that the nursing profession shares many features across countries e.g. with respect to shared values, norms and principles, shared historical dimensions, and its classification as a semi-profession (e.g. Etzioni, 1969; Katz, 1969; Lembright, 1983; Dent, 2003; Camano-Puig, 2005; Ayala et al. 2014; Manzano-Garcia and Ayala-Calvo, 2014; Koff, 2016). The findings of this research indicate that in both countries nurses tend to be cohesive in their responses to specific types of PA. More control-orientated types of PA are typically resented by nurses, especially when linked to performance-related bonuses (PRBs), regardless of whether the bonus system is non-transparent, as in the Czech case, or if an elaborate and sophisticated bonus system was implemented, as in the rare example of German Hospital NRW. In each case, feelings of inequity arose. This finding is in line with previous research which points to the difficulty of implementing performance-related reward systems for hospital nurses and which suggests that nurses value non-financial rewards more highly (Northcott, 1997; De Gieter et al., 2006; Koff, 2017). Many Czech and German nurses expressed that *in principle* they are in favour of PA and a direct, transparent link to PRB, echoing previous research which shows that healthcare staff may approve with PRB practice in principle, however in practice they tend to not be in favour (Corby et al., 2003).

While active resistance cannot be observed in any of the country cases, passive subtle forms of resistance could be discerned to discipline-orientated forms of PA. This implies treating PA as a formality and solely complying to a minimum extent with this 'necessary evil'. This is in accordance with research on PA such as by Healy (1997) who uses the term 'appraisal disdain' to describe this form of resistance defined as "disinterest or even contempt" (p. 216). Moreover, in both countries, when PRBs were applied, managerial resistance occurred in the sense that ward managers often avoided giving negative evaluations and opted to evaluate staff at similar levels. The reason for doing so has been associated with the nursing shortage and the need to retain nurses. This finding also reflects previous research which indicates that managers generally dislike policing and evaluating performance especially when linked to such outcomes (e.g. McGregor, 1957; Grint, 1993; Winstanley and Stuart-Smith, 1996; Krausert, 2009).

However, development-orientated, nurturing variants of PA were found to be perceived as positive for nurses and their own development. This is an important finding because it challenges dominant perspectives highlighted in chapter 2 which suggest that PA in whichever form is ultimately a ritualistic, ineffective practice or an inherently problematic one due to its connotations with 'control'. Instead, the findings show that PA, underpinned by developmental and nurturing purposes, can be overall beneficial to both nurses and the organisation. Conversely, limited evidence was found that discipline-orientated types of PA actually benefit the organisation (i.e. hospital) in terms of improved efficiency or performance, which is largely why the system was abandoned in the German case of NRW, and why at Czech hospital North the preference would be not to implement it if it was not a requirement for accreditation. This goes against the general assumption in the traditional PA literature that, whatever the PA approach, PA's ultimate and overarching aim or expectation is that it will improve performance (e.g. Fletcher, 2001; DeNisi, 2000; Wilson and Western, 2000; Brown et al., 2010).

### *Divergence*

Notwithstanding convergence in terms of an increased prevalence of PA across countries due to shared hospital pressures and similar nurses' reaction to certain types of PA, this thesis reveals striking national differences in the approach to PA and thus demonstrates the limits of convergence. It shows that hospitals are not necessarily adopting a rational, universalist, efficiency-driven approach regarding PA in response to wider pressures as implied by the convergence perspective and that hospitals follow neither a US nor European model (Mayrhofer and Brewster, 2005).

In using the PA typology, this thesis identifies variation in PA which can be attributed to distinctive institutions. The research identified *one key* national institution in each country: in the Czech Republic, a thus far under-researched transitional country, the thesis reveals that the system for external quality assurance (i.e. accreditation) plays a crucial role regarding PA. In Germany, the WCs play a central role in firstly, co-deciding if PA is introduced and secondly, setting the parameters of any PA systems. This finding is highly relevant to the erosion thesis, central to the convergence argument according to which traditionally strong industrial relations institutions in countries like Germany are weakening (see e.g. Addison et al., 2012) and increasingly aligning with LME countries, in turn leading to more similarity in HRM practices. This thesis instead shows, in line with the notions of the VoC model and institutional theory more generally, that in the German public hospital sector institutionalised workers' voice still plays a fundamental role and leads to more employee-friendly (i.e. nurturing and developmental) types of PA. This is because WCs tend to take a similar stance toward PA, which is in line with previous suggestions that WCs tend to be resistant towards practices which seek performance control (e.g. Kampkötter et al., 2017; Giardini et al., 2005).

Yet, as individual WCs may differ from each other, there is *scope* for some variation. Previous research suggests that WCs may handle specific issues differently depending on the specific employer-WC relations, the WCs attitude and experiences, and the specific local context (Greer et al., 2010; Jirjahn et al., 2011; Kotthoff, 2013; Marsden, 2015). This thesis discovers that the same applies to PA although in a limited sense. The exceptional case of Hospital NRW provides a rare example of a WC which via a works agreement provided wider scope for the employer to 'experiment' with different types of PA. Hence, regarding the issue of within-country variation this thesis shows that in Germany hospitals may respond in different ways to similar pressures, depending on the internal dynamics of the organisation (Greenwood and Hinings, 1996; Oliver, 1991), specifically the works council-employer relations given the scope for human agency. In fact, overall more variation was discerned in Germany than in the Czech Republic where hospitals only differed relating to whether PA had already been introduced or not. While the VoC model falls short in explaining or even acknowledging within-country variation, this element in the findings rather contrasts with the VoC model which would predicts more variation in LMEs rather than CMEs. However, eventually, a nurturing-orientated type of PA prevailed at Hospital NRW, as in Germany overall, essentially because the system was deemed inefficient and brought about a range of unintended consequences.

The Czech case exhibits a clear tendency to introduce more discipline-orientated PA, due to accreditation requirements and while accreditation could resemble the role of the WC in Germany, there is an important difference in that it is an externally imposed process. This has consequences for how PA is practiced and perceived by nurses, namely a tick-box exercise, and has implications for the quality of the PA process as was also the case at Hospital NRW with the original PA system. Due to the lack of internal ownership it was badly executed and thus the quality of the PA process suffered as well. Although little to no research has been conducted on the impact of national healthcare and quality assurance systems on PA, there have been suggestions that in those cases where PA is associated with accreditation requirements in the healthcare sector, the focus would tend to be on performance ratings and a check of tasks (Risher, 2005). This assertion was confirmed in the Czech case, leading to little internal ownership of the system. Most Czech nurses reported feeling dissatisfied with PA because of associated perceptions of increased monitoring and control while simultaneously reporting that PA is perceived as a ritual. Yet, as PA is understood to be an external requirement, it is an accepted practice. This finding corroborates the importance of attributions of the “why” in relation to HR practices (Nishii et al., 2006) as the external attribution leads nurses to comply albeit to a minimum extent with PA.

These key institutions should not be regarded in isolation, given the notion of institutional complementarities (Hall and Soskice, 2001). Particularly, country differences regarding collective bargaining arrangements has implications for the PRB component of PA, such that it provides a more formal scope for German hospitals to use bonus mechanisms in an organised way while in the Czech Republic, it was found that hospitals lack an internal bonus system with transparent rules due to the lack of regulation of PRBs either centrally or via local collective agreements. This has implications for how PA is perceived, namely as unfair given the scope for favouritism. This aspect has been previously reported although not widely (EPSU, 2017; Hedija, 2016; Saltman et al., 2011) given the lack of research on the Czech Republic.

Nevertheless, this thesis advances the literature on institutions as it shows that a hierarchy of institutions exists, meaning that it is not only important to consider the way in which institutions differ between countries but also the ‘strength’ or relative importance of institutions within a given country. The findings of this research thus moves the rather generic discussion around the role of institutions in PA forward by showing that healthcare systems have developed in distinct ways so that certain institutions are more important than others in different countries. For example, in Germany, the powerful WC cuts through other institutions and mediates their

influence so that e.g. the scope for PRBs provided in the TVöD has had limited impact in public-sector hospitals. In the Czech Republic, weak industrial relations institutions means that the influence of accreditation systems has more traction.

In both countries, the nursing profession was also considered as a potential influencing factor. As such, this study provided an up-to-date comparative analysis of nursing which is currently lacking. Differences were found regarding specific developments within nursing, so that in Germany incremental advancements within nursing was identified (e.g. establishment of first nursing chamber in one federal state), while in the Czech Republic, despite advancements since the fall of communism, nursing as a profession experiences setbacks regarding the re-organisation of nurses' education to lower levels. Nonetheless, in both countries, the status of nursing was described in similar terms and a lack of influence was identified due to, amongst other things, nursing being an incomplete profession, the lack of a (national) nursing chamber and historical dimensions of the nursing profession. Again, overall, this implies that other institutions became more important in shaping PA. Having said that, in Germany, nursing's lack of a united, influential voice is compensated by the WC, leading to more development-orientated types of PA which provide considerable degrees of freedom for ward managers and general nurses, contributing to internal ownership of the system. Also, ward managers in Germany can be suggested to try and redress the lack of influence and status of nursing at local level by encouraging more engagement, including via developmental forms of PA.

### *Summary*

In summary, this thesis advances the PA literature as it offers a detailed exploration of how and which national institutions shape PA approaches for public sector hospital nurses in Germany and the Czech Republic. It contributes empirically to this yet limited area in the PA literature and confirms the importance of national institutions in shaping PA (Festing and Knappert, 2014). It considers the PA process and outcomes as a whole within its national context rather than solely looking at individual facets of the PA process in isolation (DeNisi and Murphy, 2017). It thereby demonstrates how PA operates in a layered way so that national institutions influence the approach of PA by affecting 'why' PA systems are introduced in the first place, which has implications for 'how' PA operates, and in turn its consequences. It contributes to the literature conceptually by providing a framework for PA comparison. It contributes theoretically by applying and testing convergence and divergence arguments to PA. Support was found for convergence, however in a limited sense, namely an increased use of PA and similar reactions of nurses to certain PA types. Stronger support was found for divergence, i.e. variation regarding

the purpose, overall character and consequences of PA due to distinct dominant institutions. It also extends these debates by showing that, given how healthcare systems have developed, certain institutions are more important than others in different countries. More generally, this thesis contributes to the HR literature by moving away from a universalistic discussion of HR practices to an appreciation that HR practices are sensitive to context whether national or sectoral (Markoulli et al., 2016; Cooke et al., 2017; Meyer and Hammerschmid, 2010; Brookes et al., 2014; Björkman and Welch, 2015).

## 8.2 Policy recommendations

Practical recommendations are offered under the consideration of the specific national institutional context as this research demonstrates its important role in management decisions related to PA. In Germany, despite the collective-bargaining agreement providing the scope for linking individual PA with performance bonuses, the exceptional hospital case 'NRW' in Germany showed that hospitals should be cautious to implement it even if the WC is willing to agree. The system was deemed inefficient and time-consuming and difficult to implement in practice as e.g. appraisals had to be conducted for all general nurses at the same time of the year. Moreover, nurses did not respond well to the differentiation in bonus payments. However, given the low amount of the bonus it has otherwise limited effect on nurses. Indeed, it appears that it does not matter if bonuses are attached to team performance or if bonuses are not related to performance at all. As such, hospitals can dispense with elaborate performance-related bonus systems and focus on the developmental aspects of PA.

In general, hospital nurses benefit from development-orientated appraisal systems, both in those cases where it is focused on the individual nurse or with a focus on the team as described in hospital Rheinland-Pfalz or hospital NRW respectively. In relation to individual staff discussions, there are suggestions that this might even contribute toward the retention of nurses and better management of task allocations. 'Team-days' have the potential to contribute to e.g. improved teamwork and allocation of tasks. Hence, such types of PA have positive outcomes for the hospital in terms of e.g. retention and represent a useful tool to manage skill levels at the ward.

In the Czech Republic, given that the accreditation guidelines usually stipulate that each 'standard' should be fulfilled to at least 50 percent, accreditation bodies should clarify and hospitals find out whether more developmental-orientated PA systems would satisfy this standard sufficiently as well. External requirements and pressures can be utilised to implement

new practices in Czech hospitals, and acceptance of the workforce can be expected. However, to have positive effects for nurses and their work, hospitals should re-consider the need to grade nurses and/or incorporate more 'nurturing' elements within their PA systems. In relation to performance-related bonuses, similar recommendations as for Germany can be given. As long as the bonus amount is as low as described in the hospital cases, it will have a limited effect for nurses. Nurses at the Czech hospitals tend to place more value on gestures of appreciation (e.g. vouchers/discount for local swimming pool) rather than a small bonus. Furthermore, specifically in the Czech hospitals more should be done to ensure full transparency of how bonuses are linked to performance.

Emerging from this are general lessons on PA and recommendations for 'good practice' which extend beyond the country case studies. In general, PA approaches that score high on the development and worker autonomy dimensions bring important benefits to the employee with respect to e.g. employee satisfaction, communication and skills development, as well as to the organisation in terms of retention, the management of resources and potentially even the quality of work. Conversely, PA systems which are highly orientated towards control and primarily concerned with performance evaluation have detrimental and demotivational effects on individual employees and their teams. Especially when PA is connected to individual PRBs, these effects are exacerbated. Thus, from an organisational perspective, such PA systems are inefficient. Therefore, it is advisable that organisations concentrate on the developmental elements of PA by adopting a long-term orientation, incorporating high levels of employee participation within the PA process, mutual goal-setting, and focusing on further training, development and support (e.g. via coaching) and intrinsic rewards. It also implies providing sufficient levels of freedom to the managers carrying out PA to ensure internal ownership of the system alongside clear guidelines to ensure consistency. While the findings and corresponding recommendations relate to nursing and the hospital context, these conclusions may be relevant to similar occupational groups (e.g. teachers) and the wider public sector, although further research is warranted to examine PA approaches and their consequences in different contexts, including sectoral, occupational and national contexts (see section 8.4 on future research).

### 8.3 Limitations

There are several limitations which should be noted, which are closely linked to future research recommended in the next section. Firstly, the findings are based on the specific occupational group of general nurses who are considered a semi-profession. Findings may have differed for occupations representative of the 'full profession', as discussed in Chapter 3. In other words, if

the degree of professionalisation is higher, the profession itself might be able to influence PA practices in similar ways across countries and thereby dominate over other national institutions. This is an area for future research to explore.

Secondly, this thesis purposely focused on the exploration of public sector hospitals and the pressures these are under as a potential element of convergence between the two countries. Therefore, hospital ownership may have affected the findings as all four case study hospitals are public hospitals and subject to pressures that private hospitals are not.

Thirdly, the findings are specific to German and Czech hospitals. Further research should be conducted on further countries particularly those characterised by a LME and CME, as well as under-researched countries to further test the applicability of the VoC framework. Since the focus of the VoC model, as also of the thesis, lies on national differences this model was a useful conceptual basis for this research, however, fell short in some aspects such as in explaining within-country variation which should be borne in mind. Also, future research which is recommended to adopt a longitudinal approach (see section 8.4) to explore longer term developments, the VoC framework may not be suited due to its rigid view on path-dependency and institutional change (Crouch, 2005).

Fourthly, while the adopted research design allowed to take developments in relation to both PA and nursing into account, for example in terms of the changing nature of PA at hospital NRW and developments within the nursing profession, a longitudinal research design is necessary to be able to determine convergence versus divergence over time.

Lastly, survey results should be interpreted with caution, particularly due to the small number of respondents in the case of Hospital NRW. Furthermore, the survey results themselves do not prove causation. The survey questions utilised in this study were based on relevant parts of the British NHS staff survey, however future research would benefit from extending the survey to incorporate more questions which focus specifically on PA rather than the general hospital environment. The next section further discusses potential key avenues for future research.

## 8.4 Future research

First of all, further research needs to be conducted on PA and the impact of the national institutional context on the nature of PA across different countries. This research has clearly provided evidence for the importance of how national factors can affect the purpose of appraisal, as well as its character and consequences. It also identified the dominant national factors which have contributed to differences across Germany and the Czech Republic. However,



further research is needed on other countries representative of CMEs and LMEs in order to determine whether these factors are specific to the respective countries under investigation here or part of a wider context in terms of the 'variety of capitalism'. For example, it would be reasonable to expect similar findings to emerge to the one in Germany in other CME countries such as in the Netherlands where the role of the WC is important too. Yet, it is unclear if this one commonality would necessarily lead to similar PA approaches in hospitals. More research is particularly needed in post-communist countries.

As emerged during this research, the topic of hospital certification and accreditation is an interesting yet under-researched area in relation to PA specifically, but more generally comparative research on external accreditation and its impact on hospitals and hospital HR management practices is lacking. Interview participants highlighted the complex picture that presents itself in relation to accreditation in each country as there are various organisations who conduct these external accreditations. As such, much more research is needed on what accreditation entails, what it should entail, in how far accreditation should or should not guide management practices and whether or not this is effective across different countries.

Further, there is scope for more research on nursing in general. Many changes are occurring in many countries which concerns e.g. the education of nurses in an effort to somehow address the severe nursing shortages. This research focused on hospital nurses but more broadly nursing finds itself in a challenging context. More comparative research is needed on how more recent developments affected the nursing profession across different countries. In addition, cross-country comparative studies on PA in the context in other professional groups is valuable to investigate the way in which e.g. 'full' professions influence PA practices.

Moreover, an area for further research concerns hospital ownership patterns. Given the focus of this thesis on public hospitals and the pressures by which they are affected, further work in the two countries observed should look more into the issue of ownership and whether this makes a difference to employee perceptions of PA. More specifically, this implies not only a consideration of public versus private sector hospitals but also church hospitals (i.e. non-profit hospitals), particularly in Germany where ownership may have implications for works councils and their co-determination rights and thus PA.

Lastly, any research concerned with the convergence versus divergence of specific HRM practices would benefit from adopting longitudinal research approaches to ascertain developments over time.

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## Appendices

### **Appendix 1:**

#### **Notification form of conducted staff discussion (Hospital RP)**

<u>Staff discussion</u>		
<b>Notification of conducted staff discussion and agreed qualification/training/professional development measures</b>		
As a record of conducted staff discussion send to the Department of Personnel Development (HR) (Via internal mail, Fax: XXXX or via email xxx@xxxx.de).		
<b>Employee:</b>	<b>Manager:</b>	
<b>Time period (from – to):</b>	<b>Division:</b>	
Staff discussion (Please tick reason for discussion) <input type="checkbox"/> Feedback within the first 6 months of employment <input type="checkbox"/> Feedback –annual discussion <input type="checkbox"/> Reason: .....		
Provide trust - give competencies <b>Development plan/ Planned qualification measures</b>		
<b>Date</b>	<b>Signature Employee</b>	<b>Signature supervisor</b>
.....	.....	.....

## **Appendix 2:**

### **Appraisal at Hospital South (Healthcare Assistant)**

	<b>Applies to: Hospital "South"</b>	Issue Date:
	<b>Appraisal of employee performance</b>	1. October 2009

<b>Name of employee:</b>	<b>Grading scale</b>
<b>Department:</b>	<b>0 – not applicable</b>
<b>Position:</b> Healthcare assistant	<b>1 (A) – exceeds requirements</b>
<b>Date of appraisal:</b>	<b>2 (B) – meets requirements</b>
<b>Evaluation period:</b>	<b>3 (C) – slightly below requirements</b>
	<b>4 (D) – below requirements</b>
<b>Appraiser:</b>	<b>5 (E) – not suitable for the given position</b>

Evaluation criteria	Result	Notes
Conduct towards patients		
Conduct towards superiors and co-workers		
Teamwork skills		
Personal pace		
Ability to provide support in challenging or exceptional situations		
Organisational skills		
Initiative, effort to improve care and treatment		
Participation in introducing new (active nursing care) methods and processes		
Professional development (seminars, active participation, self-observation)		
Compliance with methodological instructions regarding nursing care, as well as guidelines relating to disinfection and sterilisation		
General preparation (nails and hands without embellishments), use of OOPP (personal protective work equipment)		
Attendance and utilisation of working time		

**Statement of the appraisee:**

I agree

I do not agree

I agree with restrictions

**Signature of the appraisee:**

**Signature of the appraiser:**

### Appendix 3:

#### Survey results (In %)

Question		N	Yes (%)	No (%)	Can't remember (%)
In the last 12 months, have you had an appraisal, annual review, development review, (...)?	Hospital RP (DE)	<b>95</b> *4 cases missing	<b>79</b>	<b>21</b>	-
	Hospital NRW (DE)	<b>26</b>	<b>46</b>	<b>54</b>	-
	Hospital South (CZ)	<b>193</b> *7 missing cases	<b>78</b>	<b>16</b>	<b>6</b>
	Hospital North (CZ)	<b>172</b> *3 missing cases	<b>39</b>	<b>55</b>	<b>6</b>
Did it help you to improve how you do your job?	Hospital RP (DE)	<b>75</b> *4 cases missing	<b>76</b>	<b>24</b>	-
	Hospital NRW (DE)	<b>12</b>	<b>67</b>	<b>33</b>	-
	Hospital South (CZ)	<b>145</b> *12 missing cases	<b>67</b>	<b>33</b>	-
	Hospital North (CZ)	<b>65</b> *5 missing cases, 105 N/A	<b>75</b>	<b>25</b>	-
Did it help you agree clear objectives for your work?	Hospital RP (DE)	<b>77</b> *2 missing cases	<b>88</b>	<b>12</b>	-
	Hospital NRW (DE)	<b>12</b>	<b>75</b>	<b>25</b>	-
	Hospital South (CZ)	<b>143</b> *14 cases missing	<b>77</b>	<b>23</b>	-
	Hospital North (CZ)	<b>63</b> *7 cases missing; 105 N/A	<b>87</b>	<b>13</b>	-
Did it leave you feeling that your work is valued by your organisation?	Hospital RP (DE)	<b>77</b> *2 missing cases	<b>79</b>	<b>21</b>	-
	Hospital NRW (DE)	<b>11</b> 1 case missing	<b>64</b>	<b>36</b>	-
	Hospital South (CZ)	<b>140</b> *17 missing cases	<b>46</b>	<b>54</b>	--
	Hospital North (CZ)	<b>60</b> *10 missing cases; 105 N/A	<b>48</b>	<b>52</b>	-
Were any training, learning or development needs identified?	Hospital RP (DE)	<b>78</b> 1 case missing	<b>85</b>	<b>15</b>	-
	Hospital NRW (DE)	<b>12</b>	<b>17</b>	<b>83</b>	-
	Hospital South (CZ)	<b>138</b> 20 cases missing	<b>56</b>	<b>44</b>	-
	Hospital North (CZ)	<b>63</b> 7 cases missing; 105 N/A	<b>63.5</b>	<b>36.5</b>	-
Did your manager support you to receive this training learning and development?	Hospital RP (DE)	<b>59</b> 7 cases missing	<b>95</b>	<b>5</b>	-
	Hospital NRW (DE)	<b>2</b>	<b>100</b>	<b>0</b>	-
	Hospital South (CZ)	<b>80</b> 17 cases missing	<b>100</b>	<b>0</b>	--
	Hospital North (CZ)	<b>48</b> 4 cases missing; 123 N/A	<b>87.5</b>	<b>12.5</b>	-



Question		N	Strongly agree	Agree	Neither/ nor	Dis- agree	Strongly disagree
<b>To what extent do you agree or disagree with the following statements about your job? (In %)</b>							
Team members have a set of shared objectives	Hospital RP (DE)	94	34.0	54.3	4.3	5.3	2.1
	Hospital NRW (DE)	25	28.0	64.0	4.0	0	4.0
	Hospital South (CZ)	155	18.7	63.9	12.3	3.9	1.3
	Hospital North (CZ)	144	10.4	66	16.7	4.2	2.8
Team members often meet to discuss the team's effectiveness	Hospital RP (DE)	96	32.3	43.8	10.4	8.3	5.2
	Hospital NRW (DE)	25	8.0	44.0	4.0	40.0	4.0
	Hospital South (CZ)	151	11.9	57.0	11.9	17.9	1.3
	Hospital North (CZ)	142	9.2	48.6	14.8	24.6	2.8
Team members have to communicate closely with each other to achieve the team's objectives	Hospital RP (DE)	96	39.6	47.9	9.4	1.0	2.1
	Hospital NRW (DE)	25	20.0	76.0	0.0	0.0	4.0
	Hospital South (CZ)	153	24.2	63.4	10.5	1.3	0.7
	Hospital North (CZ)	142	15.5	62.7	12.7	7.7	1.4
I have clear, planned goals and objectives for my job	Hospital RP (DE)	98	40.8	56.1	2.0	1.0	0
	Hospital NRW (DE)	26	11.5	73.1	7.7	0	7.7
	Hospital South (CZ)	194	21.1	58.8	12.4	5.7	2.1
	Hospital North (CZ)	168	13.7	61.9	16.1	6.2	1.8
I always know what my work responsibilities are	Hospital RP (DE)	98	53.5	44.4	1.0	1.0	0
	Hospital NRW (DE)	26	23.1	61.5	3.8	7.7	3.8
	Hospital South (CZ)	197	39.1	52.3	8.1	0.5	0
	Hospital North (CZ)	173	21.4	69.9	4.0	4.0	0.6
I am trusted to do my job	Hospital RP (DE)	99	43.4	53.5	3.0	0	0
	Hospital NRW (DE)	26	15.4	65.4	0	15.4	3.8
	Hospital South (CZ)	196	22.4	52.6	23.5	1.5	0
	Hospital North (CZ)	173	16.2	53.2	25.4	4.0	1.2
I am able to do my job to a standard I am personally pleased with	Hospital RP (DE)	99	26.3	53.5	9.1	8.1	3.0
	Hospital NRW (DE)	26	7.7	46.2	19.2	19.2	7.7
	Hospital South (CZ)	197	21.8	56.3	12.2	9.6	0
	Hospital North (CZ)	172	12.2	66.9	12.8	7.6	0.6
<b>To what extent do you agree or disagree with the following statements about your immediate manager? My immediate manager...( in %)</b>							
... encourages those who work for her/him to work as a team	Hospital RP (DE)	99	35.4	50.5	8.1	6.1	0
	Hospital NRW (DE)	26	11.5	34.6	23.1	26.9	3.8
	Hospital South (CZ)	194	18.0	53.6	17.5	10.3	0.5
	Hospital North (CZ)	173	16.2	59.0	13.3	9.2	2.3
... can be counted on to help me with a difficult task at work	Hospital RP (DE)	99	37.4	52.5	5.1	5.1	0
	Hospital NRW (DE)	26	15.4	23.1	26.9	26.9	7.7
	Hospital South (CZ)	195	26.2	47.7	15.4	9.7	1.0
	Hospital North (CZ)	172	20.3	57.0	14.5	7.6	0.6
...gives me clear feedback on my work	Hospital RP (DE)	99	36.4	49.5	10.1	4.0	0
	Hospital NRW (DE)	26	7.7	34.6	30.8	19.2	7.7
	Hospital South (CZ)	196	14.8	53.1	18.9	12.2	1.0
	Hospital North (CZ)	170	15.3	47.1	25.9	10.0	1.8
...asks for my opinion before making decisions that affect my work	Hospital RP (DE)	98	28.6	49.0	15.3	6.1	1.0
	Hospital NRW (DE)	26	7.7	23.1	19.2	38.5	11.5
	Hospital South (CZ)	196	13.3	47.4	19.9	18.4	1.0
	Hospital North (CZ)	171	13.5	49.1	19.3	17.5	0.6

...is supportive in a personal crisis	Hospital RP (DE)	97	36.1	43.3	15.5	3.1	2.1
	Hospital NRW (DE)	26	11.5	30.8	30.5	3.8	15.4
	Hospital South (CZ)	195	20.5	40.0	22.6	12.8	4.1
	Hospital North (CZ)	171	23.9	46.8	19.3	8.2	1.8
			Very satisfied	Satisfied	Neither / Nor	Dis-satisfied	Very dis-satisfied
<b>How satisfied are you with each of the following aspects of your job?</b>							
The recognition I get for good work	Hospital RP (DE)	98	18.4	45.9	14.3	15.3	6.1
	Hospital NRW (DE)	26	3.8	46.2	15.4	30.8	3.8
	Hospital South (CZ)	196	6.6	37.2	21.4	28.1	6.6
	Hospital North (CZ)	170	1.2	41.8	21.8	31.2	4.1
The support I get from my immediate manager	Hospital RP (DE)	99	23.2	57.6	9.1	10.1	0
	Hospital NRW (DE)	25	8.0	40.0	28.0	20.0	4.0
	Hospital South (CZ)	193	14.0	51.8	17.6	14.5	2.1
	Hospital North (CZ)	170	7.6	62.9	20.6	8.2	0.6
The freedom I have to choose my own method of working	Hospital RP (DE)	99	24.2	52.5	17.2	5.1	1.0
	Hospital NRW (DE)	26	7.7	34.6	30.8	19.2	7.7
	Hospital South (CZ)	195	10.8	57.4	20.0	10.8	1.0
	Hospital North (CZ)	170	2.9	51.8	26.5	18.2	0.6
The support I get from my work colleagues	Hospital RP (DE)	98	24.5	57.1	14.3	4.1	0
	Hospital NRW (DE)	26	19.2	57.7	7.7	11.5	3.8
	Hospital South (CZ)	195	15.4	62.6	14.4	6.7	1.0
	Hospital North (CZ)	173	8.7	61.3	20.8	8.1	1.2
The amount of responsibility I am given	Hospital RP (DE)	99	33.3	52.5	11.1	2.0	1.0
	Hospital NRW (DE)	26	26.9	38.5	26.9	3.8	3.8
	Hospital South (CZ)	194	10.8	67.5	12.9	7.7	1.0
	Hospital North (CZ)	171	0.6	67.3	23.4	8.8	0
The opportunities I have to use my skills	Hospital RP (DE)	99	28.3	52.5	13.1	6.1	0
	Hospital NRW (DE)	26	11.5	57.7	23.1	3.8	3.8
	Hospital South (CZ)	191	9.4	62.8	14.1	13.6	0
	Hospital North (CZ)	174	2.3	56.9	23.6	16.1	1.1
The extent to which my organisation values my work	Hospital RP (DE)	97	18.6	52.6	12.4	13.4	3.1
	Hospital NRW (DE)	26	7.7	30.8	15.4	26.9	19.2
	Hospital South (CZ)	194	8.2	38.7	24.2	22.2	6.7
	Hospital North (CZ)	172	1.7	35.5	30.8	27.9	4.1
My level of pay	Hospital RP (DE)	97	6.2	25.8	19.6	27.8	20.6
	Hospital NRW (DE)	26	3.8	30.8	15.4	30.8	19.2
	Hospital South (CZ)	197	5.1	26.4	10.7	42.1	15.7
	Hospital North (CZ)	171	1.8	22.2	9.4	47.4	19.3

Biographical data							
Gender (in %)							
	N	Female			Male		
Hospital RP (DE)	96 3 missing cases	78.1			21.9		
Hospital NRW (DE)	26	92.3			7.7		
Hospital South (CZ)	184 16 missing cases	94.0			6.0		
Hospital North (CZ)	167 8 missing cases	97.6			2.4		
Age (in %)							
	N	16-20	21-30	31-40	41-50	51-65	66+
Hospital RP (DE)	96 3 missing cases	2.1	20.8	21.9	29.2	26.0	-
Hospital NRW (DE)	26	-	15.4	19.2	42.3	23.1	-
Hospital South (CZ)	183 17 missing cases	-	10.9	26.8	33.9	27.9	0.5
Hospital North (CZ)	171 4 missing cases	0.6	9.9	25.1	36.8	26.9	.6
Working hours (in %)							
	N	Up to 29 hours			30 or more hours		
Hospital RP (DE)	96 3 missing cases	20.8			79.2		
Hospital NRW (DE)	26	38.5			61.5		
Hospital South (CZ)	181 19 missing cases	1.1			98.9		
Hospital North (CZ)	159 16 missing cases	5.0			95.0		
Tenure (in %)							
	N	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Hospital RP (DE)	97 2 missing cases	2.1	4.1	15.5	13.4	16.5	48.5
Hospital NRW (DE)	26	3.8	7.7	3.8	15.4	7.7	61.5
Hospital South (CZ)	186 14 missing cases	4.8	6.5	8.6	16.1	12.4	51.6
Hospital North (CZ)	173 2 missing cases	5.8	2.3	7.5	18.5	5.6	50.3

## **Appendix 4:**

### **Ethical approval letter**



University of London

Research Ethics Office  
King's College London  
Rm 5.2 FWB (Waterloo Bridge Wing)  
Stamford Street  
London  
SE1 9NH

**31 July 2014**

TO: Alexandra Stroleny

SUBJECT: Approval of ethics application

Dear Alexandra,

**REP/13/14-165 - Assessing pressures to perform: Comparing nurses' experiences of the individual performance appraisal in the UK, Germany and the Czech Republic**

I am pleased to inform you that full approval for your project has been granted by the **E&M** Research Ethics Panel. Any specific conditions of approval are laid out at the end of this letter which should be followed in addition to the standard terms and conditions of approval, to be overseen by your Supervisor:

- Ethical approval is granted until **31/07/2017**. You will not receive a reminder that your approval is about to lapse so it is your responsibility to apply for an extension prior to the project lapsing if you need one (see below for instructions).
- You should report any untoward events or unforeseen ethical problems arising from the project to the panel Chairman within a week of the occurrence. Information about the panel may be accessed at:  
<http://www.kcl.ac.uk/innovation/research/support/ethics/committees/sshl/rep/index.aspx>
- If you wish to change your project or request an extension of approval, please complete the Modification Proforma. A signed hard copy of this should be submitted to the Research Ethics Office, along with an electronic version to [crec-lowrisk@kcl.ac.uk](mailto:crec-lowrisk@kcl.ac.uk). Please be sure to quote your low risk reference number on all correspondence. Details of how to fill a modification request can be found at: <http://www.kcl.ac.uk/innovation/research/support/ethics/applications/modifications.aspx>
- All research should be conducted in accordance with the King's College London *Guidelines on Good Practice in Academic Research* available at:  
<http://www.kcl.ac.uk/iop/research/office/help/Assets/good20practice20Sept200920FINAL.pdf>

If you require signed confirmation of your approval please email [crec-lowrisk@kcl.ac.uk](mailto:crec-lowrisk@kcl.ac.uk) indicating why it is required and the address you would like it to be sent to.

Please would you also note that we may, for the purposes of audit, contact you from time to time to ascertain the status of your research.

We wish you every success with this work.

With best wishes

Rosie Pearson – Research Support Assistant  
**On behalf of**  
E&M REP Reviewer

## **Appendix 5:**

Consent form (English version)

### **CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES**

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

**Title of Study: Comparing performance appraisal practices and nurses' experiences in Germany and Czech Republic**



**King's College Research Ethics Committee Ref: REP/13/14-165**

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

***Please tick  
or initial***

**I confirm that I understand that by ticking/initialling each box I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes mean that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element I may be deemed ineligible for the study.**

☐

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information and asked questions which have been answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to the point of fieldwork completion (30 November 2016).

☐

3. I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act.

☐

4. I understand that my information may be subject to review by responsible individuals from the College for monitoring and audit purposes.

☐

5. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications

☐

6. I understand that the information I have submitted will be published as a report.

☐

7. I consent to my interview being audio/video recorded.

☐

\_\_\_\_\_  
**Name of Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Name of Researcher**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

## **Appendix 6:**

**Information sheet for participants (English version; interviews)**

### **INFORMATION SHEET FOR PARTICIPANTS**

REC Reference Number: **REP/13/14-165**

**Title of Study: Comparing performance appraisal practices and nurses' experiences in Germany and the Czech Republic**



I would like to invite you to participate in this research project which forms part of my PhD research. You should only participate if you want to; choosing not to take part will not disadvantage you in anyway. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

The aim of the study is to examine the state of performance management and appraisal and compare nurses' experiences of it in public sector hospitals across different EU countries: the Czech Republic and Germany. Specifically, I am interested in exploring the purpose, process and outcomes of nurses' performance appraisal. I want to incorporate a broad range of perspectives, including the nurses', managements', trade unions' and professional associations' perspectives. The type of questions we will discuss include how your organisation has implemented performance appraisal practices; why you think that is; how you have been affected by it; and what have been the main consequences for you and the workforce. The research interview will enable you to reflect in confidence on these issues.

Your views will be collected via an interview and should take approximately 40 minutes - one hour. It will be based on the interview topic guide, but it is designed to be flexible so as to meet your needs. On request, you will be able to view the questions before the interview and will not have to answer any questions which will make you feel uncomfortable. The interview will be recorded, subject to your permission. Recordings of interviews will be deleted after transcription.

What is said in the interview is regarded as strictly confidential and will be held securely until the research is finished. Your participation is entirely voluntary. If you change your mind, you are free to stop your participation and to have your data withdrawn without giving any reason before the completion of the fieldwork (November 2016). All data for analysis will be anonymised. In reporting on the research findings, I will not reveal the names of any participants or the organisation where you work. At all times there will be no possibility of you as individuals being linked with the data. The UK Data Protection Act 1998 will apply to all information gathered within the interviews.

King's College London is funding this research. The study has been approved by the King's College London Research Ethics Committee.

If you have any questions or require more information about this study, please contact me using the following contact details:

Alexandra Stroleny, King's College London, Department of Management, Franklin-Wilkins Building, 150 Stamford Street, London SE1 9NH

Tel: UK: 07897 802504; Germany: 0173 8998558; Email: [alexandra.stroleny@kcl.ac.uk](mailto:alexandra.stroleny@kcl.ac.uk)

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact King's College London using the details below for further advice and information: The Chair, Social Science and Public Policy, Humanities and Law, Research Ethics Subcommittee Chair, [rec@kcl.ac.uk](mailto:rec@kcl.ac.uk)

**Thank you for reading this information sheet and for considering taking part in this research.**

Alexandra Stroleny



## **Appendix 7:**

**Information sheet for participants (English version; questionnaires)**

### **INFORMATION SHEET FOR PARTICIPANTS - Questionnaire**



*REC Reference Number:* **REP/13/14-165**

**Title of Study: Comparing nurses' experiences of individual performance appraisal in the Czech Republic and Germany**

I would like to invite you to participate in this research project which forms part of my PhD research. You should only participate if you want to; choosing not to take part will not disadvantage you in anyway. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

The aim of the study is to examine the state of performance management and appraisal and compare nurses' experiences of it in public sector hospitals across different EU countries: the Czech Republic and Germany. Specifically, I am interested in exploring the purpose, process and consequences of nurses' performance appraisal.

Your views will be collected by filling out this questionnaire. If you decide to participate in this research, the questionnaire will cover questions about performance appraisal and how you have been affected by it. It will also ask a few questions about your satisfaction in terms of your working environment and a few questions about yourself, including how long you have been working at the current hospital. There are no right or wrong answers. It will take about 15 minutes to complete and you can complete it at your convenience by the --/--/--. Once completed, please put your questionnaire in the envelope provided and then in the slot in the sealed box.

Submitting a completed questionnaire implies consent to participate. As participation is anonymous it will not be possible to withdraw your data once you have returned the questionnaire. The completed questionnaire will be treated completely anonymously and confidentially. You will not be identified individually and it will only be seen by me – not by anyone else – and will not affect you in any way whatsoever. All of the information gathered will be used only for the purpose of this research and will only be accessible to the researcher. Furthermore, the data gathered will be destroyed once the project has been completed.

King's College London is funding this research. The study has been approved by the King's College London Research Ethics Committee.

If you have any questions or require more information about this study, please contact me using the following contact details:

Alexandra Stroleny, King's College London, Department of Management, Franklin-Wilkins Building, 150 Stamford Street, London SE1 9NH

Tel: UK: 07897 802504; Germany: 0173 8998558; Email: [alexandra.stroleny@kcl.ac.uk](mailto:alexandra.stroleny@kcl.ac.uk)

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact King's College London using the details below for further advice and information: The Chair, Social Science and Public Policy, Humanities and Law, Research Ethics Subcommittee Chair, [rec@kcl.ac.uk](mailto:rec@kcl.ac.uk)

**Thank you for reading this information sheet and for considering taking part in this research.**

Alexandra Stroleny

## **Appendix 8**

### **Interview Guide**

#### **Background**

- Can you tell me about your role and responsibilities as xxx?
- Role of your organisation?

#### **Current hospital and nursing context**

- General developments and pressures for hospitals?
- Current status of nursing? Unique features of nursing in Germany/Czech Republic?
- How would you describe the status of nurses in this country?
- Role of professional associations/ trade unions? Education?

#### **HRM & performance appraisal**

- Personnel management practices in the nursing area (differences between hospitals?)
- What do you understand under the term 'performance management' and 'performance appraisal'? Important for nurses?
- What role does performance appraisal play in hospitals?
  - WHY
    - Impetus/reason for introduction of performance appraisal?
    - Who decides + Potential obstacles for its introduction?
    - How is criteria for appraisal decided upon? Unique for hospital or general guidelines?
  - HOW
    - Key features of the performance appraisal process
    - Who is responsible for the performance appraisal of nurses?
    - Issues covered in performance appraisal interview?
    - Is performance appraisal linked in any way to rewards?
    - Is staff participation and voice an important element of PA?
    - Developmental, target-orientated, assessment orientated...
  - CONSEQUENCES
    - Advantages/disadvantages for hospitals overall and for individual nurse
    - In how far does performance appraisal facilitate the achievement of objectives of hospitals?
    - Improved quality? Motivation of staff?
- Planned changes?